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ABSTRACT

This TIP, on the best practice guidelines for treatment of substance use disorders, was compiled from an increasing body of research literature that documents the effectiveness of brief interventions and therapies in both the mental health and substance abuse treatment fields. It links research to practice by providing counselors with up-to-date information on the usefulness of these treatment forms for selected subpopulations of people with substance abuse disorders or for those at risk. The manual states that brief interventions and therapies are less costly, yet effective, in substance abuse treatment. Brief interventions have been found to be effective for a range of problems; they can greatly improve substance abuse treatment by making it available to a greater number of people and by tailoring the level of treatment to the level of client need. This TIP includes sections on brief interventions and therapy in substance abuse treatment, along with sections on brief therapies in the fields of cognitive-behavioral, strategic/interactional, humanistic and existential, psychodynamic, family, and group counseling. Appendixes include "Bibliography," "Information and Training Resources," " Glossary," "Health Promotion Workbook," "Resource Panel," and "Field Reviewers." (Contains 43 figures and approximately 450 resources.) (JDM)

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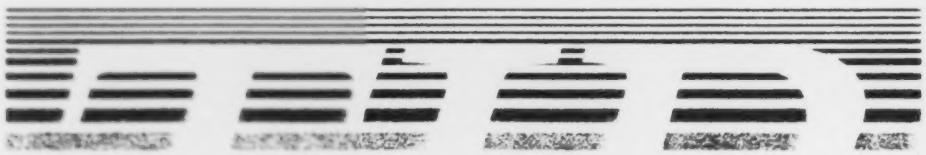
Center for Substance Abuse Treatment

Brief Interventions And Brief Therapies For Substance Abuse

Treatment Improvement Protocol (TIP) Series

34



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Screening and Brief Interventions for Alcoholism

Screen

At each visit, ask about alcohol use

- How many drinks per week?
- Maximum drinks per occasion in past month?

Use CAGE questions to probe for alcohol problems

- Have you ever tried to Cut down on your drinking?
- Do you get Annoyed when people talk about your drinking?
- Do you feel Guilty about your drinking?
- Have you ever had an Eye-opener? (A drink first thing in the morning)

Screen is positive if

- Consumption is greater than 14 drinks per week or greater than 4 drinks per occasion (men)
- Consumption is greater than 7 drinks per week or greater than 3 drinks per occasion (women)
- CAGE score is greater than 1

Then assess for

- *Medical problems:* e.g., blackouts, depression, hypertension, trauma, abdominal pain, liver dysfunction, sexual problems, sleep disorders
- *Laboratory:* elevated gamma-glutamyl transpeptidase or other liver function tests; elevated mean corpuscular volume; positive blood alcohol concentrations
- *Behavioral problems:* work, family, school, accidents
- *Alcohol dependence:* a score of 3 or higher on CAGE or one or more of the following: compulsion to drink, impaired control, withdrawal symptoms, increased tolerance, relief drinking

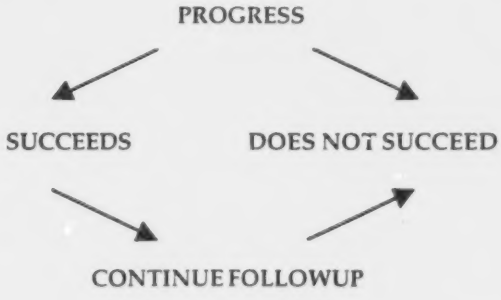
Client Feedback and Plan of Action

CSAT Treatment Improvement Protocol (TIP) 34: **Brief Interventions and Brief Therapies for Substance Abuse**

Give specific feedback to the patient, then advise—in a firm but empathic manner

If diagnosed as at risk

- Advise patient of risk
- Advise abstinence/moderation
- Set consumption goals
- Schedule followup to discuss progress



If diagnosed as substance dependent

- Advise patient of objective evidence
- Advise on plan of action
- Assess acute risk of intoxication/withdrawal
- Medical/psychiatric comorbidities
- Agree on plan of action

Plan of action

- Involve family: refer for family treatment and self-help (e.g., Al-Anon, etc.) (must have patient permission and involvement)
- Abstinence should be stressed
- Urge patient to attend self-help meetings (Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, etc.)
- Consider referral to addiction medicine specialist, and/or possible pharmacotherapy with disulfiram (Antabuse) or Naltrexone (ReVia)

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Brief Interventions And Brief Therapies for Substance Abuse

Treatment Improvement Protocol (TIP) Series

34

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The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT, SAMHSA, or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized client care and treatment decisions.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse disorders, provided as a service of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcoholism and other substance abuse disorders are increasingly recognized as major problems.

The TIPs Editorial Advisory Board, a distinguished group of substance abuse experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Other Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which it reaches consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://text.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving and that research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Brief Interventions and Brief Therapies for Substance Abuse*, is intended primarily for counselors and therapists working in the substance abuse treatment field, but parts of it will be of value to other audiences, including health care workers, social services providers, clergy, teachers, and criminal justice personnel. In fact, those portions of this TIP dealing with brief interventions will be of use to any professional service provider who may need to make an intervention to help persons with substance abuse disorders alter their use patterns or seek treatment. However, brief therapy should only be practiced by those who are properly qualified, educated, and licensed.

The first chapter of this TIP presents an overview of brief interventions and brief therapies, describing their basic characteristics and the reasons for increased interest in them. Chapter 2 describes the goals and components of brief interventions, and Chapter 3 discusses some of the basic elements of all brief therapies. Chapters 4 through 9 each highlight a different type of brief therapy, describing the theory behind it as well as some of the techniques developed from that theory that can be used to treat clients with substance abuse disorders. Separate chapters are presented describing cognitive–behavioral therapy, strategic/interactional therapies, humanistic and existential therapies, psychodynamic therapies, family therapy, and group therapy. Appendixes are also included that provide resources for further information and training, a glossary of terms used in the TIP, and a sample workbook for use in brief interventions.

The goal of this TIP is to make readers aware of the research, results, and promise of brief interventions and brief therapies in the hope that they will be used more widely in clinical practice and treatment programs across the United States.

Other TIPs may be ordered by contacting SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance abuse by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses its particular areas of expertise until it reaches consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary and Recommendations

This Treatment Improvement Protocol (TIP) responds to an increasing body of research literature that documents the effectiveness of brief interventions and therapies in both the mental health and substance abuse treatment fields. The general purpose of this document is to link research to practice by providing counselors and therapists in the substance abuse treatment field with up-to-date information on the usefulness of these innovative and shorter forms of treatment for selected subpopulations of people with substance abuse disorders and those at risk of developing them. The TIP will also be useful for health care workers, social service providers who work outside the substance abuse treatment field, people in the criminal justice system, and anyone else who may be called on to intervene with a person who has substance abuse problems.

Brief interventions and brief therapies have become increasingly important modalities in the treatment of individuals across the substance abuse continuum. The content of the interventions and therapies will vary depending on the substance used, the severity of problem being addressed, and the desired outcome.

Because brief interventions and therapies are less costly yet have proven effective in substance abuse treatment, clinicians, clinical researchers, and policymakers have increasingly focused on them as tools to fill the gap between primary prevention efforts and more intensive treatment for persons with serious substance abuse disorders. However, studies have shown that brief interventions are effective for a range of problems, and the Consensus Panel believes that their selective use can greatly improve substance abuse treatment by making them available to a greater number of people and by tailoring the level of treatment to the level of client need.

Brief interventions can be used as a method of providing more immediate attention to clients on waiting lists for specialized programs, as an initial treatment for nondependent at-risk and hazardous substance users, and as adjuncts to more extensive treatment for substance-dependent persons.

Brief therapies can be used to effect significant changes in clients' behaviors and their understanding of them. The term "brief therapy" covers several treatment approaches derived from a number of theoretical schools, and this TIP considers many of them. The types of therapy presented in these chapters have been selected for a variety of reasons, but by no means do they represent a comprehensive list of therapeutic approaches currently in practice. Some of these approaches (e.g., cognitive–behavioral therapy) are supported by extensive research; others (e.g., existential therapy) have not been, and perhaps cannot be, tested in as rigorous a manner.

This TIP presents the historical background, outcomes research, rationale for use, and state-of-the-art practical methods and case scenarios for implementation of brief interventions and therapies for a range of problems related to substance abuse. This TIP is based on the body of research conducted on brief interventions and brief therapies for substance abuse as well as on the broad clinical expertise of the Consensus Panel. Because many therapists and other practitioners are eclectically trained, elements from each of the chapters may be of use to a range of professionals.

This discussion of brief therapies is in no way intended to detract from the value of longer term therapies that clinicians have found to be effective in the treatment of substance abuse disorders. However, the Consensus Panel believes it necessary to discuss innovative and/or often-used theories that members have encountered and applied in their clinical practice.

The Consensus Panel's recommendations summarized below are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2). Citations for the former are referenced in the body of this document, where the guidelines are presented in full detail. Many of the recommendations made in the latter chapters of this TIP are relevant only within a particular theoretical framework (e.g., the Panel might recommend how a person practicing strategic therapy should approach a particular situation); because such recommendations are not applicable to all readers, they have not been included in this Executive Summary.

Throughout this TIP, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition [DSM-IV] [American Psychiatric Association, 1994]). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, it will be used to denote both substance dependence and substance abuse. The term includes the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine the meaning; in most cases, the term will refer to all varieties of substance abuse disorders as described by DSM-IV.

Summary and Recommendations

Brief Interventions

Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

A brief intervention, however, is only one of many tools available to clinicians. It is not a substitute for care for clients with a high level of dependency. It can, however, be used to engage clients *who need specialized treatment* in specific aspects of treatment programs, such as attending group therapy or Alcoholics Anonymous (AA) meetings.

- The Consensus Panel believes that brief interventions can be an effective addition to substance abuse treatment programs. These approaches can be particularly useful in treatment settings when they are used to address specific targeted client behaviors and issues in the treatment process that can be difficult to change using standard treatment approaches. (2)
- Variations of brief interventions have been found to be effective both for motivating alcohol-dependent individuals to enter

long-term alcohol treatment and for treating some alcohol-dependent persons. (1)

- The Consensus Panel recommends that programs use quality assurance improvement projects to determine whether the use of a brief intervention or therapy in specific treatment situations is enhancing treatment. (2)
- The Consensus Panel recommends that agencies allocate counselor training time and resources to these modalities. It anticipates that brief interventions will help agencies meet the increasing demands of the managed care industry and fill the gaps that have been left in client care. (2)
- Substance abuse treatment personnel should collaborate with other providers (e.g., primary care providers, employee assistance program, wellness clinic staff, etc.) in developing plans that include both brief interventions and more intensive care to help keep clients focused on treatment and recovery. (2)

Goals of brief interventions

The basic goal of any brief intervention is to reduce the risk of harm that could result from continued use of substances. The specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered.

- Focusing on intermediate goals allows for more immediate success in the intervention and treatment process, whatever the long-term goals may be. Intermediate goals might include quitting one substance, decreasing frequency of use, or attending a meeting. Immediate successes are important to keep the client motivated. (2)
- When conducting a brief intervention, the clinician should set aside the final treatment goal (e.g., accepting responsibility for one's own recovery) to focus on a single behavioral objective. Once this objective is established, a brief intervention can be used to help reach it. (2)

Components of brief interventions

There are six elements that are critical for effective brief interventions. (1) The acronym FRAMES was coined to summarize these six components:

- *Feedback* is given to the individual about personal risk or impairment.
- *Responsibility* for change is placed on the participant.
- *Advice* to change is given by the clinician.
- *Menu* of alternative self-help or treatment options is offered to the participant.
- *Empathic* style is used by the counselor.
- *Self-efficacy* or optimistic empowerment is engendered in the participant.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issues in the context of the client's health.
2. Screening, evaluating, and assessing.
3. Providing feedback.
4. Talking about change and setting goals.
5. Summarizing and reaching closure.

Providers may not have to use all five of these components in any given session with a client. However, before eliminating steps in the brief intervention process there should be a well-defined reason for doing so. (2)

Essential knowledge and skills for brief interventions

Providing effective brief interventions requires the clinician to possess certain knowledge, skills, and abilities. The following are four essential skills (2):

1. An overall attitude of understanding and acceptance

2. Counseling skills such as active listening and helping clients explore and resolve ambivalence
3. A focus on intermediate goals
4. A working knowledge of the stages-of-change through which a client moves when thinking about, beginning, and trying to maintain new behavior

Brief Therapies

Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. The brief therapies presented in this TIP should be seen as separate modalities of treatment, not episodic forms of long-term therapy.

Brief therapies usually feature more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 to 40 sessions, with the typical therapy lasting between 6 and 20 sessions.

Brief therapies also differ from brief interventions in that their goal is to provide clients with tools to change basic attitudes and handle a variety of underlying problems. Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes the effective use of therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change.

Research concerning relative effectiveness of brief versus longer term therapies for a variety of presenting complaints is mixed. However, there is evidence suggesting that brief therapies are often as effective as lengthier treatments for certain populations.

- The best outcomes for brief therapy may depend on clinician skills, comprehensive assessments, and selective criteria for eligibility. Using selective criteria in prescribing brief therapy is critical, since many clients will not meet its eligibility requirements. (2)
- Brief therapy for substance abuse treatment is a valuable approach, but it should *not* be considered a standard of care for all populations. (1) The Consensus Panel hopes that brief therapy will be adequately investigated in each case before managed care companies and third-party payors decide it is the only modality for which they will pay.
- Brief interventions and brief therapies are well suited for clients who may not be willing or able to expend the significant personal and financial resources necessary to complete more intensive, longer term treatments. (2)
- Both research and clinical expertise indicate that individuals who are functioning in society but have patterns of excessive or abusive substance use are unlikely to respond positively to some forms of traditional treatment, but some of the briefer approaches to intervention and therapy can be extremely useful clinical tools in their treatment. (1)

When to use brief therapy

Determining when to use a particular type of brief therapy is an important consideration for counselors and therapists. The Panel recommends that client needs and the suitability of brief therapy be evaluated on a case-by-case basis. (2) Some criteria for considering the appropriateness of brief therapy for clients include

- Dual diagnosis issues
- The range and severity of presenting problems
- The duration of substance dependence
- Availability of familial and community supports
- The level and type of influence from peers, family, and community
- Previous treatment or attempts at recovery
- The level of client motivation

- The clarity of the client's short- and long-term goals
- The client's belief in the value of brief therapy
- The numbers of clients needing treatment

The following criteria are derived from Panel members' clinical experience:

- Less severe substance dependence, as measured by an instrument like the Addiction Severity Index (ASI)
- Level of past trauma affecting the client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment

The Consensus Panel also notes that

- Planned brief therapy can be adapted as part of a course of serial or intermittent therapy. When doing this, the therapist conceives of long-term treatment as a number of shorter treatments, which require the client's problems to be addressed serially rather than concurrently. (1)
- Brief therapies will be most effective with clients whose problems are of short duration and who have strong ties to family, work, and community. However, a number of other conditions, such as limited client resources, may also dictate the use of brief therapy. (2)
- It is essential to learn the client's perceived obstacles to engaging in treatment as well as to identify any dysfunctional beliefs that could sabotage the engagement process. The critical factor in determining an individual's response is the client's self-perception and associated emotions. (1)

Components of effective brief therapy

While there are a variety of different schools of brief therapy available to the clinician, all forms of brief therapy share some common characteristics (2):

- They are either problem focused or solution focused—they target the symptom, not its causes.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the therapist.
- They rely on rapid establishment of a strong working relationship between client and therapist.
- The therapeutic style is highly active, empathic, and sometimes directive.
- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help the client enhance his self-efficacy and understand that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

Screening and assessment

Screening and assessment are critical initial steps in brief therapy. Screening is a process in which clients are identified according to characteristics that indicate they are possibly abusing substances. Screening identifies the need for more in-depth assessment but is not an adequate substitute for complete assessment.

Assessment is a more extensive process that involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it. Screening and assessment procedures for

brief therapy do not differ significantly from those used for lengthier treatments.

- Clinicians can use a variety of brief assessment instruments, many of which are free. These instruments should be supplemented in the first session by a clinical assessment interview that covers current use patterns, history of substance use, consequences of substance abuse, coexisting psychiatric disorders, major medical problems and health status, education and employment status, support mechanisms, client strengths and situational advantages, and family history. (2)
- The screening and assessment process should determine whether the client's substance abuse problem is suitable for a brief therapy approach. (2)
- Assessment is critical not only before beginning brief therapy but also as an ongoing part of the process. (2)
- Therapists who primarily provide brief therapy should be adept at determining early in the assessment process which client needs or goals are appropriate to address. Related to this, and equally important, the therapist must establish relationships that facilitate the client's referral when her needs or goals cannot be met through brief therapy. (2)

The first session

In the first session, the main goals for the therapist are to gain a broad understanding of the client's presenting problems, begin to establish rapport and an effective working relationship, and implement an initial intervention, however small.

- Counselors should gather as much information as possible about a client before the first counseling session. However, when gathering information about a client from other sources, counselors must be sensitive to confidentiality and client consent issues. (2)
- Therapists should identify and discuss the goals of brief therapy with the client early in treatment, preferably in the first session. (2)
- Although abstinence is an optimal clinical goal, it still must be negotiated with the client (at least in outpatient treatment settings). Abstinence as a goal is not necessarily the sole admission requirement for treatment, and the therapist may have to accept an alternative goal, such as decreased substance use, in order to engage the client effectively. (2)
- The provider of brief therapy must accomplish certain critical tasks during the first session (2), including
  - Producing rapid engagement
  - Identifying, focusing, and prioritizing problems
  - Working with the client to develop a treatment plan and possible solutions for substance abuse problems
  - Negotiating the approach toward change with the client (which may involve a contract between client and therapist)
  - Eliciting client concerns about problems and solutions
  - Understanding client expectations
  - Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
  - Making referrals for critical needs that have been identified but cannot be met within the treatment setting

Maintenance strategies, termination of therapy, and followup

Maintenance strategies must be built into the treatment design from the beginning. A practitioner of brief therapy must continue to provide support, feedback, and assistance in setting realistic goals. Also, the therapist should

help the client identify relapse triggers and situations that could endanger continued sobriety. (2)

Strategies to help clients maintain the progress made during brief therapy include the following (2):

- Educating the client about the chronic, relapsing nature of substance abuse
- Considering which circumstances might cause a client to return to treatment and planning how to address them
- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future
- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors
- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups, family support, and community support

Termination of therapy should always be planned in advance. (2) When the client has made the agreed-upon behavior changes and has resolved some problems, the therapist should prepare to end the brief therapy. If a client progresses more quickly than anticipated, it is not necessary to complete the full number of sessions.

Therapist characteristics

Therapists will benefit from a firm grounding in theory and a broad technical knowledge of the many different approaches to brief therapy that are available. (2) When appropriate, elements of different brief therapies may be combined to provide successful outcomes. However, it is important to remember that the effectiveness of highly defined interventions (e.g., workbook-driven interventions) used in some behavioral therapies depends on administration of the entire regimen.

- The therapist must use caution in combining and mingling certain techniques and must be sensitive to the cultural context within which therapies are integrated. (2)
- Therapists should be sufficiently trained in the therapies they are using and should not rely solely on a manual such as this to learn those therapies. (2)
- Training for brief therapies, in contrast to the training necessary to conduct brief interventions, requires months to years and usually results in a specialist degree or certification. The Consensus Panel recommends that anyone seeking to practice the therapies outlined here should receive more thorough training appropriate to the type of therapy being delivered. (Appendix B of the TIP provides contact information for some organizations that may be able to provide such training.) (2)
- Providers of brief therapy should be able to focus effectively on identifying and adhering to specific therapeutic goals in treatment. (2)
- Providers who practice brief therapy should be able to distill approaches from longer term therapies and apply them within the parameters of brief therapy. (2)

Cognitive–Behavioral Therapy

CBT represents the integration of principles derived from behavioral theory, cognitive social learning theory, and cognitive therapy, and it provides the basis for a more inclusive and comprehensive approach to treating substance abuse disorders.

CBT can be used by properly licensed and trained mental health practitioners even if they have limited experience with this type of therapy—either as a cost-effective primary approach or in conjunction with other therapies or a 12-Step program. CBT can be also used early in and throughout the treatment process

whenever the therapist feels it is important to examine a client's inaccurate or unproductive thinking that could lead to risky or negative behaviors. (2)

CBT is generally not appropriate for certain clients, namely, those

- Who have psychotic or bipolar disorders and are not stabilized on medication
- Who have no stable living arrangements
- Who are not medically stable (as assessed by a pretreatment physical examination) (2)

Cognitive–behavioral techniques

The cognitive–behavioral model assumes that substance abusers are deficient in coping skills, choose not to use those they have, or are inhibited from doing so. It also assumes that over the course of time, substance abusers develop a particular set of effect expectancies based on their observations of peers and significant others abusing substances to try to cope with difficult situations, as well as through their own experiences of the positive effects of substances.

- CBT is generally effective because it helps clients recognize the situations in which they are likely to use substances, find ways of avoiding those situations, and cope more effectively with the variety of situations, feelings, and behaviors related to their substance abuse. (2) To achieve these therapeutic goals, CBT incorporates three core elements:
  - *Functional analysis*—This analysis attempts to identify the antecedents and consequences of substance abuse behavior, which serve as triggering and maintaining factors.
  - *Coping skills training*—A major component in CBT is the development of appropriate coping skills.
  - *Relapse prevention*—These approaches rely heavily on functional analyses, identification of high-risk relapse situations, and coping skills training, but also incorporate additional features. These approaches attempt to deal directly with a number of the cognitions involved in the relapse process and focus on helping the individual gain a more positive self-efficacy.
- Overall, behavioral, cognitive, and cognitive–behavioral interventions are effective, can be used with a wide range of substance abusers, and can be conducted within the timeframe of brief therapies. (1)
- A broad range of cognitions will be evaluated in CBT, including attributions, appraisals, self-efficacy expectancies, and substance-related effect expectancies. (2)

Strategic/Interactional Therapies

Strategic/interactional therapies attempt to identify the client's strengths and actively create personal and environmental situations in which success can be achieved. The primary strength of strategic/interactional approaches is that they shift the focus from the client's weaknesses to his strengths.

The strategic/interactional model has been widely used and successfully tested on persons with serious and persistent mental illnesses. (1) Although the research to date on these therapies (using nonexperimental designs) has not focused on substance abuse disorders, the use of these therapies in treating substance abuse disorders is growing.

The Consensus Panel believes that these therapeutic approaches are potentially useful for clients with substance abuse disorders and should be introduced to offer new knowledge and techniques for treatment providers to consider. (2)

Using strategic/interactional therapies

No matter which type of strategic/interactional therapy is used, this approach can help to

- Define the situation that contributes to substance abuse in terms meaningful to the client (2)
- Identify steps needed to control or end substance abuse (2)
- Heal the family system so it can better support change (2)
- Maintain behaviors that will help control substance abuse (2)
- Respond to situations in which the client has returned to substance use after a period of abstinence (2)

Strategic/interactional approaches are most useful in

- Learning how the client's relationships deter or contribute to substance abuse (2)
- Shifting power relationships (2)
- Addressing fears (2)

Most forms of strategic/interactional therapies are brief by the definition used in this TIP. Strategic/interactional therapies normally require 6 to 10 sessions, with 6 being most common.

Humanistic and Existential Therapies

Humanistic and existential psychotherapies use a wide range of approaches to the planning and treatment of substance abuse disorders. They are, however, united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Humanistic and existential approaches share a belief that people have the capacity for self-awareness and choice. However, the two schools come to this belief through different theories.

Humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner resources, and establish the client as the person responsible for recovery. Thus, clients may be more likely to see beyond the limitations of short-term treatment and envision recovery as a lifelong process of working to reach their full potential. (2)

Using humanistic and existential therapies

Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's subjective experience) can be useful in any type of brief therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process. (2)

Humanistic and existential approaches can be used at all stages of recovery in creating a foundation of respect for clients and mutual acceptance of the significance of their experiences. (2) There are, however, some therapeutic moments that lend themselves more readily to one or more specific approaches.

- *Client-centered* therapy can be used immediately to establish rapport and to clarify issues throughout the session. (2)
- *Existential* therapy may be used most effectively when a client has access to emotional experiences or when obstacles must be overcome to facilitate a client's entry into or continuation of recovery (e.g., to get someone who insists on remaining helpless to accept responsibility for her actions). (2)
- *Narrative* therapy can be used to help the client conceptualize treatment as an opportunity to assume authorship and begin a "new chapter" in life. (2)
- *Gestalt* approaches can be used throughout therapy to facilitate a genuine encounter with the therapist and the client's own experience. (2)

- *Transpersonal* therapy can enhance spiritual development by focusing on the intangible aspects of human experience and awareness of unrealized spiritual capacity. (2)

Using a humanistic or existential therapy framework, the therapist can offer episodic treatment, with a treatment plan that focuses on the client's tasks and experiences between sessions. (2)

For many clients, momentary circumstances and other problems surrounding substance abuse may seem more pressing than notions of integration, spirituality, and existential growth, which may be too remote from their immediate situation to be effective. In such instances, humanistic and existential approaches can help clients focus on the fact that they do indeed make decisions about substance abuse and are responsible for their own recovery. (2)

Psychodynamic Therapies

Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behavior. The goals of psychodynamic therapy are client self-awareness and understanding of the past's influence on present behavior. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and/or desire to abuse substances.

Several of the brief forms of psychodynamic therapy are less appropriate for use with persons with substance abuse disorders, partly because their altered perceptions make it difficult to achieve insight and problem resolution. However, many psychodynamic therapists use forms of brief psychodynamic therapy with substance-abusing clients in conjunction with traditional substance abuse treatment programs or as the sole therapy for clients with coexisting disorders. (2)

Although there is some disagreement in the details, psychodynamic brief therapy is generally thought more suitable for (2)

- Those who have coexisting psychopathology with their substance abuse disorder
- Those who do not need or who have completed inpatient hospitalization or detoxification
- Those whose recovery is stable
- Those who do not have organic brain damage or other limitations to their mental capacity

Integrating psychodynamic concepts into substance abuse treatment

Most therapists agree that people with substance abuse disorders comprise a special population, one that often requires more than one approach if treatment is to be successful. Therapists whose orientations are not necessarily psychodynamic may still find these techniques and approaches useful, and therapists whose approaches are psychodynamic may be more effective if they conduct psychotherapy in a way that complements the full range of services for clients with substance abuse disorders. (2)

Family Therapy

For many individuals with substance abuse disorders, interactions with their family of origin, as well as their current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is particularly appropriate when the client exhibits signs that his substance abuse is strongly influenced by family members' behaviors or communications with them. (2)

Family involvement is often critical to success in treating many substance abuse

disorders—most obviously in cases where the family is part of the problem. (2)

Family therapy can be used to

- Focus on the expectation of change within the family (which may involve multiple adjustments)
- Test new patterns of behavior
- Teach how a family system works—how the family supports symptoms and maintains needed roles
- Elicit the strengths of every family member
- Explore the meaning of the substance abuse disorder within the family

Appropriateness of brief family therapy

Long-term family therapy is not usually necessary for the treatment of substance abuse disorders. While family therapy may be very helpful in the initial stages of treatment, it is often easier to continue to help an individual work within the family system through subsequent individual therapy. (2)

Short-term family therapy is an option that could be used in the following circumstances (2):

- When resolving a specific problem in the family and working toward a solution
- When the therapeutic goals do not require in-depth, multigenerational family history, but rather a focus on present interactions
- When the family as a whole can benefit from teaching and communication to better understand some aspect of the substance abuse disorder

Definitions of "family"

Family therapy can involve a network that extends beyond the immediate family, involves only a few members of the family system, or even deals with several families at once. (2) The definition of "family" varies in different cultures and situations and should be defined by the client.

Therapists can "create" a family by drawing on the client's network of significant contacts. (2) A more important question than whether the client is living with a family is, "Can the client's problem be seen as having a relational (involving two or more people) component?"

Using brief family therapies

In order to promote change successfully within a family system, the therapist will need the family's permission to enter the family space and share their closely held confidences. The therapy, however, will work best if it varies according to the cultural background of the family. (1)

Most family therapy is conducted on a short-term basis. Sessions are typically 90 minutes to 2 hours in length. The preferred timeline for family therapy is not more than 2 sessions per week (except in residential settings), to allow time to practice new behaviors and experience change. Therapy may consist of as few as 6 or as many as 10 sessions, depending on the purpose and goals of the intervention.

Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other.

Appropriateness of group therapy

Group psychotherapy can be extremely beneficial to individuals with substance abuse problems. (2) It gives them the opportunity to see the progression of abuse and dependency in themselves and others; it also provides an opportunity to experience personal success and the success of other group members in an atmosphere of support and hope.

Use of psychodrama techniques in a group setting

Psychodrama has long been effectively used with substance-abusing clients in a group setting. Psychodrama can be used with different models of group therapy. It offers persons with substance abuse disorders an opportunity to better understand past and present experiences—and how past experiences influence their present lives. (2)

Using time-limited group therapy

The focus of time-limited therapeutic groups varies a great deal according to the model chosen by the therapist. Yet some generalizations can be made about several dimensions of the manner in which brief group therapy is implemented.

Client preparation is particularly important in any time-limited group experience. Clients should be thoroughly assessed before their entry into a group for therapy. (2) Group participants should be given a thorough explanation of group expectations.

The preferred timeline for time-limited group therapy is not more than 2 sessions per week (except in the residential settings), with as few as 6 sessions in all, or as many as 12, depending on the purpose and goals of the group.

Sessions are typically 1½ to 2 hours in length. Residential programs usually have more frequent sessions.

Group process therapy is most effective if participants have had time to find their roles in a group, to "act" these roles, and to learn from them. The group needs time to define its identity, develop cohesion, and become a safe environment in which there is enough trust for participants to reveal themselves. (2)

Conclusion

The brief interventions and therapies described in this TIP are intended to introduce a range of techniques to clinicians. Clinicians will find different portions of this TIP more useful than others depending on their theoretical orientation, but all clinicians who work with substance-abusing clients should find material of value here. Brief interventions will be useful for a wide variety of service providers; brief therapies are intended for properly qualified, educated, and licensed professionals.

1 Introduction to Brief Interventions and Therapies

The use of brief intervention and brief therapy techniques has become an increasingly important part of the continuum of care in the treatment of substance abuse problems. With the health care system changing to a managed model of care and with changes in reimbursement policies for substance abuse treatment, these short, problem-specific approaches can be valuable in the treatment of substance abuse problems. They provide the opportunity for clinicians to increase positive outcomes by using these modalities independently as stand-alone interventions or treatments and as additions to other forms of substance abuse and mental health treatment. They can be used in a variety of settings including opportunistic settings (e.g., primary care, home health care) and specialized substance abuse treatment settings (inpatient and outpatient).

Used for a variety of substance abuse problems from at-risk use to dependence, brief interventions can help clients reduce or stop abuse, act as a first step in the treatment process to determine if clients can stop or reduce on their own, and act as a method to change specific behaviors before or during treatment. For example, there are some issues associated with treatment compliance that benefit from a brief, systematic, well-planned intervention such as attending group sessions or doing homework. In other instances, brief interventions address specific family problems with a client and/or family members or deal with specific individual problems such as personal finances and work attendance. The basic goal for a client regardless of setting is to reduce the risk of harm that may result from continued use of substances. The reduction of harm, in its broadest sense, pertains to the clients themselves, their families, and the community.

The brief therapies discussed in this TIP are brief cognitive–behavioral therapy, brief strategic and interactional therapies, brief humanistic and existential therapies, brief psychodynamic therapy, short-term family therapy, and time-limited group therapy. The choice to include these therapeutic modalities was based on a combination of relevant research and, in some instances where there is a smaller research base, the clinical knowledge and expertise of the Consensus Panel. All of these approaches are currently being used in the treatment of substance abuse disorders, and all of them can contribute something to the array of treatment techniques available to the eclectic practitioner.

Brief interventions and brief therapies may be thought of as elements on a continuum of care, but they can be distinguished from each other according to differences in outcome goals. Interventions are generally aimed at motivating a client to perform a particular action (e.g., to enter treatment, change a behavior, think

differently about a situation), whereas therapies are used to address larger concerns (such as altering personality, maintaining abstinence, or addressing long-standing problems that exacerbate substance abuse). This TIP presents brief interventions as a way of improving client motivation for treatment. The brief therapies considered here are ways of changing client attitudes and behaviors. Other differences that help distinguish brief interventions from brief therapies include

- Length of the sessions (from 5 minutes for an intervention to more than six 1-hour therapy sessions)
- Extensiveness of assessment (which will be greater for therapies than for interventions)
- Setting (nontraditional treatment settings such as a social service or primary care setting, which will use interventions exclusively, versus traditional substance abuse treatment settings where therapy or counseling will be used in addition to interventions)
- Personnel delivering the treatment (brief interventions can be administered by a wide range of professionals, but therapy requires training in specific therapeutic modalities)
- Materials and media used (certain materials such as written booklets or computer programs may be used in the delivery of interventions but not therapies)

Although the theoretical bases for brief therapy and brief intervention may be different, this distinction is less obvious in practice. These two approaches to substance abuse problems and behavior change reflect a continuum rather than a clear dichotomy. The distinction may be further blurred as the change process associated with the success of brief interventions is better understood or refined and as theories are developed to explain a brief intervention's mechanism of action. Already, some forms of brief intervention overlap with therapy, such as motivational enhancement therapy, which has a clearly articulated theoretical rationale (for more on this topic, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment*, which was conceived as a companion volume to this TIP [Center for Substance Abuse Treatment (CSAT), 1999c]).

For the purposes of this TIP, brief therapy involves a series of steps taken to treat a substance abuse problem, whereas brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse. Therapy involves movement (or an attempt at movement) toward change. Brief therapy concentrates particularly on investigating a problem in order to develop a solution in consultation with the client; brief interventions generally involve a therapist giving advice to the client.

The increasing emphasis on brief approaches is partly attributable to recent changes in the health care delivery system, in which clinicians are urged to reduce costs while maintaining treatment efficacy. Essentially, clinicians are constrained by time and diminishing resources yet are treating an increasing number of individuals with substance abuse problems.

Fortunately, there is a body of literature on brief approaches in the treatment of substance abuse disorders. Brief interventions and brief therapies have the appeal not only of being brief but also of having research backing that supports their use. Brief interventions have been widely tested with both general clinical and substance-abusing populations and have shown great promise in changing client behavior. Brief therapies, however, have been unevenly researched. As indicated in the discussion of each type, in addition to the empirical results reported in scientific journals, clinical and anecdotal evidence supports the efficacy of brief therapies in the treatment of substance abuse. The brevity and lower

delivery costs of these brief approaches make them ideal mechanisms for use in settings from primary care to substance abuse treatment where cost often plays as much of a role as efficacy in determining what treatments clients receive.

Brief interventions and brief therapies are also well suited for clients who may not be willing or able to expend the significant personal and financial resources necessary to complete more intensive, longer term treatments. Although much research supports the theory that longer time in treatment is associated with better outcomes, research also suggests that for some clients, there is no loss in effectiveness when length and intensity of treatment are reduced.

An Overview of Brief Interventions

Definitions of brief interventions vary. In the recent literature, they have been referred to as "simple advice," "minimal interventions," "brief counseling," or "short-term counseling." They can be simple suggestions to reduce drinking given by a professional (e.g., social worker, nurse, alcohol and drug counselor, physician, physician assistant) or a series of interventions provided within a treatment program. As one researcher notes,

> Brief interventions for excessive drinking should not be referred to as an homogenous entity, but as a family of interventions varying in length, structure, targets of intervention, personnel responsible for their delivery, media of communication and several other ways, including their underpinning theory and intervention philosophy (Heather, 1995, p. 287).

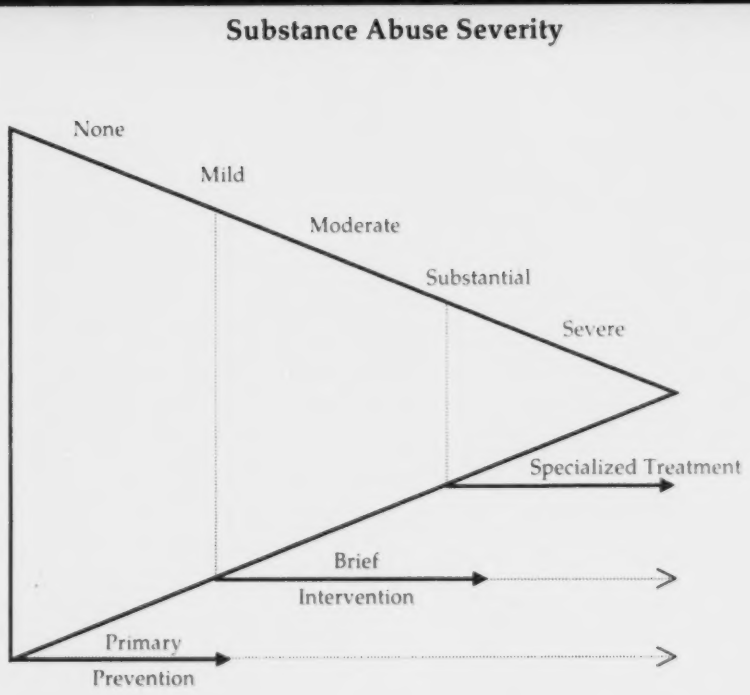
Brief interventions, therefore, can be viewed as a set of principles regarding interventions which are different from, but not in conflict with, the principles underlying conventional treatment (Heather, 1994).

Brief interventions for alcohol problems, for example, have employed various approaches to change drinking behaviors. These approaches have ranged from relatively unstructured counseling and feedback to more formal structured therapy and have relied heavily on concepts and techniques from the behavioral self-control training (BSCT) literature (Miller and Hester, 1986b; Miller and Munoz, 1982; Miller and Rollnick, 1991; Miller and Taylor, 1980) (see Chapter 4 for more information on BSCT). Usually, brief treatment interventions have flexible goals, allowing the individual to choose moderation or abstinence. The typical counseling goal is to motivate the client to change her behavior and not to assign self-blame. While much of the research to date has centered on clients with alcohol-related problems, similar approaches can be taken with users of other substances.

Brief interventions are a useful component of a full spectrum of treatment options; they are particularly valuable when more extensive treatments are unavailable or a client is resistant to such treatment. Too few clinicians, however, are educated and skilled in the use of brief interventions and therapies to address the very large group of midrange substance users who have moderate and risky consumption patterns (see Figure 1-1). Although this group may not need or accept traditional substance abuse treatment, these individuals are nonetheless responsible for a disproportionate share of substance-related morbidity, including lowered workforce performance, motor vehicle accidents and other injuries, marital discord, family dysfunction, and medical illness (Wilk et al., 1997). These hazardous substance users are identified in employment assistance programs (EAPs), programs for people cited for driving while intoxicated (DWI), and urine testing programs, as well as in physicians' offices and other health screening efforts (Miller, 1993). Despite appeals from such distinguished bodies

Figure 1-1

Substance Abuse Severity and Level of Care



The triangle represents the population of the United States with the range of problems experienced by the population shown along the upper side. A spectrum of responses to these substance abuse problems is shown along the lower side (based on Skinner, 1988). In general, specialized treatment is indicated for persons with substantial or severe problems, brief intervention is indicated for persons with mild or moderate problems, and primary prevention is indicated for persons who have not had problems but who are at risk of developing them. The dotted lines extending the arrows suggest that both primary prevention and brief intervention may have effects beyond their principal target populations. The prevalence of substance abuse problems in the population is represented by the area of the triangle occupied; most people have no substance abuse problems, many people have a few substance abuse problems, and some people have many substance abuse problems.

Source: Adapted with permission from the Institute of Medicine, 1990.

as the National Academy of Sciences in the United States and the National Academy of Physicians and Surgeons in the United Kingdom, widespread adoption of brief interventions by medical practitioners or treatment providers has not yet occurred (Drummond, 1997; Institute of Medicine [IOM], 1990).

Brief interventions in traditional settings usually involve a more in-depth assessment of substance abuse patterns and related problems 1990). The characterizations of hazardous, harmful, or dependent use as they relate to alcohol consumption patterns (Edwards et al., 1981) were used to distinguish the targets of

brief intervention in a World Health Organization (WHO) study (Babor and Grant, 1991). Hazardous drinking refers to a level of alcohol consumption or pattern of drinking that, should it persist, is likely to result in harm to the drinker. Harmful drinking is defined as alcohol use that has already resulted in adverse mental or physical effects. Dependent use refers to drinking that has resulted in physical, psychological, or social consequences and has been the focus of major diagnostic tools, such as the *Diagnostic and Statistical Manual*, 4th Edition (American Psychiatric Association [APA], 1994) or the *International Classification of Diseases*, 9th Revision (ICD-9) (ICD-9-CM, 1995). Categorizing drinking patterns in this fashion provides both clinicians and researchers with flexible guidelines to identify individuals at risk for alcohol problems who may not meet criteria for alcohol dependence. Similar levels of use for other substances are much more difficult to define, since most of them are illicit and those that are not have often not been widely studied in relation to substance abuse.

Studies of brief interventions have been conducted in a wide range of health care settings, from hospitals and primary health care locations (Babor and Grant, 1991; Chick et al., 1985; Fleming et al., 1997; Wallace et al., 1988) to mental health clinics (Harris and Miller, 1990). (Refer to "Research Findings" in Chapter 2 for more discussion of research on brief interventions.) Individuals recruited from such settings are likely to have had some contact with a health care professional during the study participation and therefore had alcohol-related professional assistance available. Nonetheless, many of these patients would not be identified as having an alcohol problem by their health care providers and would not ordinarily receive any alcohol-specific intervention.

In general, brief interventions are conducted in a variety of opportunistic and substance abuse treatment settings, target different goals; may be delivered by treatment staff or other professionals, and do not require extensive training. Because of the short duration of brief intervention strategies, they can be considered for use with injured patients in the emergency department who have substance abuse problems. Useful distinctions between the goals of brief interventions as applied in different settings are listed in Figure 1-2.

Brief interventions in traditional settings usually involve a more in-depth assessment of substance use patterns and related problems than interventions administered in nontraditional settings and tend to examine other aspects of participants' attitudes, such as readiness for or resistance to change. They can be useful for addressing specific behavior change issues in treatment settings. Because they are timely, focused, and client centered, brief interventions can quickly enhance the overall working relationship with clients. However, brief interventions should not be a care substitute for clients who have a high level of abuse.

Some of the assessments conducted for research studies of brief interventions are very extensive and may have been conducted during prior treatment (e.g., in detoxification programs, during treatment intake procedures). Most brief interventions offer the client detailed feedback about assessment findings, with an opportunity for more input. The assessment typically involves obtaining information regarding frequency and quantity of substance abuse, consequences of substance abuse, and related health behaviors and conditions.

The intervention itself is structured and focused on substance abuse. Its primary goals are to raise awareness of problems and then to recommend a specific change or activity (e.g., reduced consumption, accepting a referral, self-monitoring of substance abuse). The participant in a brief intervention is usually offered a menu of options or strategies for accomplishing the

Figure 1-2
Goal of Brief Interventions According to Setting

Setting	Purpose
Opportunistic setting	■ Facilitate referrals for additional specialized treatment (e.g., a nurse identifying substance-abusing clients through screening and advising them to seek further assessment or treatment) ■ Affect substance abuse directly by recommending a reduction in hazardous or at-risk consumption patterns (e.g., a primary care physician advising hazardous or at-risk drinkers to cut down, National Alcohol Screening Day) or establishing a plan for abstinence
Neutral environments (e.g., individuals responding to media advertisements)	■ Assess substance abuse behavior and give supportive advice about harm reduction (e.g., a public health initiative to screen people in shopping malls and provide feedback and advice)
Health care setting	■ Facilitate referrals for additional specialized treatment
Substance abuse treatment programs	■ Act as a temporary substitute for more extended treatment for persons seeking assistance but waiting for services to become available (e.g., an outpatient treatment center that offers potential clients assessment and feedback while they are on a waiting list) ■ Act as a motivational prelude to engagement and participation in more intensive treatment (e.g., an intervention to help a client commit to inpatient treatment when the assessment deems it appropriate but the client believes outpatient treatment is adequate) ■ Facilitate behavior change related to substance abuse or associated problems

Source: Adapted from Bien et al., 1993.

target goal and encouraged to take responsibility for selecting and working on behavioral change in a way that is most comfortable for him. Any followup visits will provide an opportunity to monitor progress and to encourage the client's motivation and ability to make positive changes. The person delivering the brief intervention is usually trained to be empathic, warm, and encouraging rather than confrontational.

Brief interventions are typically conducted in face-to-face sessions, with or without the addition of written materials such as self-help manuals, workbooks, or self-monitoring diaries. A few have consisted primarily of mailed materials, automated computer screening and advice, or telephone contacts.

Some interventions are aimed at specific health problems that are affected by substance abuse, rather than substance abuse itself.

For example, an intervention may be conducted to help a client reduce her chances of contracting human immunodeficiency syndrome (HIV) by using clean needles; as a result, if the client only has dirty needles, she might avoid using them in order to reduce her risk of HIV and thus reduce her use of heroin. By raising an individual's awareness of her substance abuse, a brief intervention can act as a powerful catalyst for changing a substance abuse pattern.

The distress clients feel about their substance abuse behavior can act as an influence to encourage change as they recognize the negative consequences of that behavior to themselves or others. Positive and negative external forces are also influences. Life events, such as a major illness or the death of significant others, career change, marriage, and divorce, can contribute to the desire to change. Brief interventions can address these events and feelings that accompany them with the underlying goal of changing clients' substance abuse behaviors.

An Overview of Brief Therapies

In contrast to most simple advice or brief interventions, brief therapies are usually delivered to persons who are seeking—or already in—treatment for a substance abuse disorder. That is, the individual usually has some recognition or awareness of the problem, even if he has yet to accept it. The therapy itself is often client driven; the client identifies the problems, and the clinician uses the client's strengths to build solutions. The choice of a brief therapy for a particular individual should be based on a comprehensive assessment rather than a cursory screening to identify potentially hazardous drinking or substance-abusing patterns (IOM, 1990). In some cases, brief therapy may also be used if resources for more extensive therapy are not available or if standard treatment is inaccessible or unavailable (e.g., remote communities, rural areas). Brief therapies often target a substance-abusing population with more severe problems than those for whom brief interventions are sufficient. Brief therapies can be useful for special populations if the therapist understands that some client issues may be developmental or physiological in nature (see TIP 26, *Substance Abuse Among Older Adults*, and TIP 32, *Treatment of Adolescents With Substance Use Disorders* [CSAT, 1998b, 1999b]).

Although brief therapies are typically shorter than traditional versions of therapy, these therapies generally require at least six sessions and are more intensive and longer than brief interventions. Brief therapy, however, is not simply a shorter version of some form of psychotherapy. Rather, it is the focused application of therapeutic techniques specifically targeted to a symptom or behavior and oriented toward a limited length of treatment.

In addition to the goals of brief interventions, the goals of brief therapy in substance abuse treatment is remediation of some specified psychological, social, or family dysfunction as it pertains to substance abuse; it focuses primarily on present concerns and stressors rather than on historical antecedents. Brief therapy is conducted by therapists who have been specifically trained in one or more psychological or psychosocial models of treatment. Therapist training requires months or years and usually results in a specialist degree or certification. In practice, many therapists who have been trained in specific theoretical models of change borrow techniques from other models when working with their clients. Although the models remain distinct, therapists often become eclectic practitioners.

The Demand for Brief Interventions and Therapies

The impetus for shorter forms of interventions and treatments for a range of substance abuse problems comes from several sources:

- Historical developments in the field that encourage a comprehensive, community-based continuum of care—with treatment and prevention components to serve clients who have a wide range of substance abuse-related problems
- A growing body of evidence that consistently demonstrates the efficacy of brief interventions
- An increasing demand for the most cost-effective types of treatment, especially in this era of health care inflation and cost containment policies in the private and public sectors
- Client interest in shorter term treatments

The increasing demand for treatment of some sort—arising from the identification of more at-risk consumers of substances through EAPs, substance-testing programs, health screening efforts, and drunk driving arrests—coupled with decreased public funding and cost containment policies of managed care leave only two options: provide diluted treatment in traditional models for a few or develop a system in which different levels and types of interventions are provided to clients based on their identified needs and characteristics (Miller, 1993).

Expanding Treatment Options

The development of public substance abuse treatment programs subsidized by Federal, State, and local monies dates to the late 1960s when public drunkenness was decriminalized and detoxification centers were substituted for drunk tanks in jails. At about the same time, similar efforts were made to curtail heroin use in major cities by establishing methadone maintenance clinics and residential therapeutic communities (IOM, 1990).

By the 1980s, direct Federal financial support for treatment had slowed, and although some States continued to grant subsidies, the most rapid growth in the field switched to the insurance-supported private sector and the development of treatment programs targeted primarily to heavy consumers of alcohol, cocaine, and marijuana (Gerstein and Harwood, 1990). The standardized approach used in most of these private, hospital-based programs incorporated many aspects of the Minnesota model pioneered in the late 1950s, with a strong focus on the 12-Step philosophy developed in Alcoholics Anonymous (AA), a fixed-length, 28-day stay, and insistence on abstinence as the major treatment goal (CSAT, 1995).

Initially, treatment programs in both the public and private sectors tended to serve the most seriously impaired populations; however, providers gradually recognized the need for treatment options for a wider range of clients who had different types of substance abuse disorders. Providers realized that not all clients benefit from a single standardized treatment approach. Rather, treatment should be tailored to individual needs determined by in-depth assessments of the client's problems and antecedents to her substance abuse disorder. Providers were also aware that interventions with less dysfunctional clients often had greater success rates. In the interest of reducing drunk driving, for example, educational efforts were targeted at offenders charged with DWI as an alternative to revoking their driving licenses. In such programs, more attention was given to outcomes and factors in the treatment setting than to the client's history; these seemed to affect success rates whether or not treatment was completed.

As assessments became more comprehensive, treatment also began to address the effects of substance abuse patterns on multiple systems, including physical and mental health, social and personal functioning, legal entanglements, and economic stability. In recent years, this biopsychosocial approach to the treatment of substance abuse disorders has stimulated more cross-disciplinary cooperation. It has also prompted more attempts to match client needs to the most appropriate and expeditious intensity of care and treatment modality. Consideration is now given to differences not only in the severity and types of problems identified but also to the cultural or environmental context in which the problems are encountered, the types of substances abused, and differences in gender, age, education, and social stability. Determining a client's appropriateness for treatment is one of the 46 global criteria for competency of certified alcohol and drug abuse counselors (Herdman, 1997). Indeed, client assessment and treatment matching and referral has become a specialty area in itself that avoids the hazards of random treatment entry.

In order to test the efficacy of current treatment-matching knowledge, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) initiated Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity), which assessed the benefits of matching alcohol-dependent clients (using 10 client characteristics) to three types of treatments: 12-Step facilitation, cognitive–behavioral therapy, and motivational enhancement therapy (Project MATCH Research Group, 1997). Clients from two parallel but independent clinical trials (one in which clients were receiving outpatient treatment, the other in which clients were receiving aftercare therapy following inpatient treatment) were assigned to receive one of the three treatments. Although the results do not indicate a strong need to consider client characteristics to match clients to treatment, the findings do suggest that the severity of coexisting psychiatric disorders should be considered.

Another study, conducted by McLellan and colleagues, identified specific problems of clients in treatment (e.g., employment, family, psychiatric problems), then matched the clients to services designed to address the problems (McLellan et al., 1993). These clients stayed in treatment longer, were more likely to complete treatment, and had better posttreatment outcomes than unmatched clients in the same treatment programs.

In this context, increasing emphasis has also been given to integrating specialized approaches to substance abuse treatment with the general medical system and the services of other community agencies. A 1990 IOM report called for more community involvement in health care, social services, workplace, educational, and criminal justice systems (IOM, 1990). Because the vast majority of persons who use substances in moderation experience few or minor problems, they are not likely to seek help in the specialized treatment system. Instead, the estimated 20 percent of the adult population who drink or use heavily or in inappropriate ways (Higgins-Biddle et al., 1997) are those most likely to come to the attention of physicians, social workers, family therapists, employers, teachers, lawyers, and police. Because the prevalence of harmful and risky substance use far exceeds the capacity of available services to treat it, briefer and less intensive interventions seem warranted for a broad range of individuals, including those who are unwilling to accept referral for more formal and extensive specialized care (Bien et al., 1993) and those whose substance use is risky but not abusive (Higgins-Biddle et al., 1997).

Cost and Funding Factors

Studies of the cost-effectiveness of different treatment approaches have been particularly appealing to policymakers seeking to reduce costs and better allocate scarce resources. In the managed care environment, however, cost containment has become a byword, and no standard type of care or treatment protocol for all clients is acceptable. In order to receive reimbursement, substance abuse treatment facilities must find the least intensive yet safe modality of care that can be objectively proven to be appropriate and effective for a client's needs. Now that more treatment is delivered in ambulatory care facilities, the usual time in treatment is being shortened, and the credibility of recommended treatment approaches must be increasingly documented through carefully conducted research studies. In this context, some of the most widely used substance abuse treatment approaches, such as the Minnesota model, halfway houses, and 12-Step programs, have only recently been subjected to rigorous tests of effectiveness in controlled clinical trials (Barry, 1997; Holder et al., 1991; Landry, 1996).

In addition to the emphasis on cost containment and careful client–treatment matching, other researchers tout the potentially enormous public health impact that could be derived from conducting mass screenings in existing health care and other community-based systems to identify problem drinkers and then delivering brief interventions aimed at reducing excessive drinking patterns (Kahan et al., 1995). If appropriately selected persons with less severe substance abuse respond successfully to brief interventions with a consequent long-term reduction in substance abuse-related morbidity and associated health care costs, time and energy could be saved for treating those with more severe substance abuse disorders in specialized treatment facilities.

Barriers to Increasing the Use of Brief Treatments

Many clinicians and other care providers in community agencies retain the long-standing notion that clients are generally resistant to change, unmotivated, and in denial of problems associated with their substance abuse disorders. As a result, clinicians are hesitant to work with this population. Some of these attitudes also persist in the specialist treatment community (Miller, 1993). Although this perspective is shifting as clinicians better understand the many aspects of client motivation, there is still a tradition of waiting for a substance user to "hit bottom" and ask for help before attempting to treat him.

Other ideological obstacles present barriers in earlier stages of substance abuse. The focus of brief interventions on harm or risk reduction and moderating consumption patterns as a first and sometimes only goal is not always acceptable to counselors who were trained to insist on total and enduring abstinence. Assumptions underlying brief interventions aimed at harm reduction may seem to challenge ideas that substance abuse disorders are a chronic and progressive disease requiring specialized treatment. However, if substance abuse is placed on a continuum from abstinence to severe abuse, any move toward moderation and lowered risk is a step in the right direction and not incongruous with a goal of abstinence as the ultimate form of risk reduction (Marlatt et al., 1993). Moreover, research indicates that substance-abusing individuals who are employed and generally functioning well in society are unlikely to respond positively to some forms of traditional treatment which may, for example, tell them that they have a primary disease of substance dependency and must abstain from all psychoactive substances for life (Miller, 1993).

In addition to resisting a harm reduction approach, treatment staffs in programs that incorporate pharmacotherapies may be skeptical of behavioral approaches to client change if they believe addiction primarily stems from disordered brain chemistry that should be treated medically. There are many models of pharmacotherapy that suggest that counseling (often in a brief form) coupled with medication provides the most well-rounded and comprehensive treatment regime (McLellan et al., 1993; Volpicelli et al., 1992).

Moreover, research reveals that a longer time in treatment may contribute to a greater likelihood of success (Lamb et al., 1998). Brief interventions challenge this assumption by acknowledging that spontaneous remission and self-directed change in substance abuse behaviors do occur. A new perspective might reconcile these observations by recognizing that limited treatment can be beneficial—especially considering that at least half of all clients drop out of specialized treatment before completion.

Probably the largest impediment to broader application of briefer forms of treatment is the already overwhelming responsibilities of frontline treatment staff members who are overworked and unfamiliar with the latest treatment research findings (Schuster and Silverman, 1993). Not only are these clinicians reluctant to make clinical changes, but their programs may also lack the financial and personnel resources to adopt innovative approaches. Treatment programs limit themselves by such inability and unwillingness to learn new techniques.

Evaluating Brief Interventions and Therapies

Quality improvement has become an important consideration in the contemporary health care environment. Because of changes in the nature and provision of health care delivery in the United States, health care organizations have been working to develop systematic quality improvement programs to monitor provision of care, client satisfaction, and costs. Brief interventions can be an important part of a treatment program's quality improvement initiative. These approaches can be used to improve treatment outcomes in specific areas. Not only can brief interventions improve client compliance with specific aspects of treatment and therapist morale by focusing on attainable goals, but they can also demonstrate specific clinical outcomes of importance to both clinicians and managed care systems.

Importance of Evaluation

The Consensus Panel recommends that programs use quality assurance improvement projects to determine whether the use of a brief intervention or therapy in specific treatment situations is improving treatment. Examples of outcome measures include

- Aftercare followup rates
- Aftercare compliance rates
- Alumni participation rates
- Discharge against medical advice rates
- Counselors' ratings of client involvement in substance abuse following treatment
- The number of complaints related to the brief intervention or therapy

Mechanisms To Use in Evaluation

The effects of adding brief approaches to standard care should be evaluated as part of continuous quality improvement program testing. Some of these outcomes can be measured by

- Client satisfaction surveys
- Followup phone calls
- Counselor-rating questions added to clinical chart

Programs should monitor client satisfaction over time, and whenever possible counselors should be involved in quality improvement activities. Identifying trends over time can indicate what improvements need to be made. Implementation of substance abuse prevention and brief intervention strategies in clinical practice requires the development of systematized protocols that can provide easier service delivery. The need to implement effective and unified strategies for a variety of substance abusers who are at risk for more serious health, social, and emotional problems is high, both from a public health and a clinical perspective. As the health care system undergoes changes, programs should take the opportunity to develop and advocate a comprehensive system of substance abuse interventions, combining the skills of clinicians with the knowledge gained from the research community.

2 Brief Interventions in Substance Abuse Treatment

Brief interventions for substance abuse problems have been used for many years by alcohol and drug counselors, social workers, psychologists, physicians, and nurses, and by social service agencies, hospital emergency departments, court-ordered educational groups, and vocational rehabilitation programs. Primary care providers find many brief intervention techniques effective in addressing the substance abuse issues of clients who are unable or unwilling to access specialty care. Examples of brief interventions include asking clients to try nonuse to see if they can stop on their own, encouraging interventions directed toward attending a self-help group (e.g., Alcoholics Anonymous [AA] or Narcotics Anonymous [NA]), and engaging in brief, structured, time-limited efforts to help pregnant clients stop using.

Brief interventions are research-proven procedures for working with individuals with at-risk use and less severe abuse behaviors and can be successful when transported into specialist treatment settings and performed by alcohol and drug counselors. As presented in the literature, brief interventions to change substance abuse behaviors can involve a variety of approaches, ranging from unstructured counseling and feedback to formal structured therapy (Chick et al., 1985; Fleming et al., 1997; Kristenson et al., 1983; Persson and Magnusson, 1989). Brief interventions, as defined and discussed in this TIP are time limited, structured, and directed toward a specific goal. They follow a specific plan (and in some cases a workbook) and have timelines for the adoption of specific behaviors.

Several studies have attempted to identify factors that result in differential responses to brief intervention by varying client characteristics or by conducting subgroup analyses. Most studies of brief interventions to date are limited by their lack of sufficient subject assessments. Findings from the available research suggest that client characteristics are not good predictors of a person's response to a brief intervention and that brief interventions may be applicable to individuals from a wide range of cultures and backgrounds (Babor, 1994; Babor and Grant, 1991).

This chapter provides theoretical and practical information on brief interventions, both in opportunistic settings and in the substance abuse treatment setting. The stages-of-change model is presented first because of its usefulness in understanding the process of behavioral change. Next, the goals of brief intervention are described and applied to various levels of substance use. FRAMES elements critical to brief intervention are detailed, and five essential steps are listed with scripts to use in various settings. The brief intervention workbook, a practical tool for use during a brief intervention, is explained.

Essential clinician knowledge and skills for conducting a successful brief intervention are then described. Discussions of the use of brief intervention in substance abuse programs and nonspecialized settings follow. The final section presents research findings on brief interventions for both at-risk users and dependent users.

Stages-of-Change Model

The work of Prochaska and DiClemente and their "stages-of-change" model help clinicians tailor brief interventions to clients' needs (Prochaska and DiClemente, 1984, 1986). Prochaska and DiClemente examined several theories concerning how change occurs and applied their findings to substance abuse behavior modification. They devised a model consisting of five stages of change that seemed to best represent the process people go through when thinking about, beginning, and trying to maintain new behavior (see Figure 2-1). The stages-of-change model is explained more fully in TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999c).

These stages have proven useful, for example, in predicting those most likely to quit smoking and in targeting specific kinds of interventions to smokers in different stages (DiClemente et al., 1991; Prochaska, 1999; Prochaska and DiClemente, 1986; Velicer et al., 1992). Stages of change are being examined in brief interventions with hazardous and harmful substance users as well, as a means of tailoring interventions to the individual's current stage of change (Hodgson and Rollnick, 1992; Mudd et al., 1995).

Clients need motivational support appropriate to their stage of change. If the clinician does not use strategies appropriate to the stage the client is in, treatment resistance or noncompliance could result. To consider change, clients at the precontemplation stage must have their awareness raised. To resolve their ambivalence, clients in the contemplation stage must be helped to choose positive change over their current circumstances. Clients in the preparation stage need help in identifying potential change strategies and choosing the most appropriate ones. Clients in the action stage need help to carry out and comply with the change strategies.

The clinician can use brief interventions to motivate particular behavioral changes at each stage of this process. For example, in the contemplation stage, a brief intervention could help the client weigh the costs and benefits of change. In the preparation stage, a similar brief intervention could address the costs and benefits of various change strategies (e.g., self-change, brief treatment, intensive treatment, self-help group attendance). In the action stage, brief interventions can help maintain motivation to continue on the course of change by reinforcing personal decisions made at earlier stages.

Understanding these stages helps the clinician to be patient, to accept the client's current position, to avoid "getting too far ahead" of the client and thereby provoking resistance, and, most important, to apply the correct counseling strategy for each stage of readiness. Effective brief interventionists quickly assess the client's stage of readiness, plan a corresponding strategy to assist her in progressing to the next stage, and implement that strategy without succumbing to distraction. Indeed, clinician distraction can be a greater obstacle to change in brief intervention than time limitations. Regardless of the stage of readiness, brief interventions can help initiate change, continue it, accelerate it, and prevent the client from regressing to previous behaviors.

Figure 2-1
The Stages of Change

Stage	Example	Treatment Needs
Precontemplation. The user is not considering change, is aware of few negative consequences, and is unlikely to take action soon.	A functional yet alcohol-dependent individual who drinks himself into a stupor every night but who goes to work every day, performs his job, has no substance abuse-related legal problems, has no health problems, and is still married.	This client needs information linking his problems and potential problems with his substance abuse. A brief intervention might be to educate him about the negative consequences of substance abuse. For example, if he is depressed, he might be told how his alcohol abuse may cause or exacerbate the depression.
Contemplation. The user is aware of some pros and cons of substance abuse but feels ambivalent about change. This user has not yet decided to commit to change.	An individual who has received a citation for driving while intoxicated and vows that next time she will not drive when drinking. She is aware of the consequences but makes no commitment to stop drinking, just to not drive after drinking.	This client should explore feelings of ambivalence and the conflicts between her substance abuse and personal values. The brief intervention might seek to increase the client's awareness of the consequences of continued abuse and the benefits of decreasing or stopping use.
Preparation. This stage begins once the user has decided to change and begins to plan steps toward recovery.	An individual who decides to stop abusing substances and plans to attend counseling, AA, NA, or a formal treatment program.	This client needs work on strengthening commitment. A brief intervention might give the client a list of options for treatment (e.g., inpatient treatment, outpatient treatment, 12-Step meetings) from which to choose, then help the client plan how to go about seeking the treatment that is best for him.
Action. The user tries new behaviors, but these are not yet stable. This stage involves the first active steps toward change.	An individual who goes to counseling and attends meetings but often thinks of using again or may even relapse at times.	This client requires help executing an action plan and may have to work on skills to maintain sobriety. The clinician should acknowledge the client's feelings and experiences as a normal part of recovery. Brief interventions could be applied throughout this stage to prevent relapse.
Maintenance. The user establishes new behaviors on a long-term basis.	An individual who attends counseling regularly, is actively involved in AA or NA, has a sponsor, may be taking disulfiram (Antabuse), has made new sober friends, and has found new substance-free recreational activities.	This client needs help with relapse prevention. A brief intervention could reassure, evaluate present actions, and redefine long-term sobriety maintenance plans.

Source: Adapted from Prochaska and DiClemente, 1984.

Goals of Brief Intervention

The basic goal for a client in any substance abuse treatment setting is to reduce the risk of harm from continued use of substances. The greatest degree of harm reduction would obviously result from abstinence, however, the specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered. Focusing on intermediate goals allows for more immediate successes in the intervention and treatment process, whatever the long-term goals are. In specialized treatment, intermediate goals might include quitting one substance, decreasing frequency of use, attending the next meeting, or doing the next homework assignment. Immediate successes are important to keep the client motivated.

Setting goals for clients is particularly useful in centers that specialize in substance abuse treatment. Performing brief interventions in this setting requires the ability to simplify and reduce a client's treatment plan to smaller, measurable outcomes, often expressed as "objectives" in the Joint Commission on the Accreditation of Healthcare Organizations' (JCAHO) language of treatment planning. The clinician must be aware of the many everyday circumstances in which clients with substance abuse disorders face ambivalence during the course of treatment.

The key to a successful brief intervention is to extract a single, measurable behavioral change from the broad process of recovery that will allow the client to experience a small, incremental success. Clients who succeed at making small changes generally return for more successes.

The clinician should temporarily set aside the final goal (e.g., accepting responsibility for one's own recovery) to focus on a single behavioral objective. Once this objective is established, a brief intervention can be used to reach it. Objectives vary according to the client's stage of recovery and readiness to change, but brief interventions can be useful at any stage of recovery. Figure 2-2 presents several objectives that might be addressed with a brief intervention.

The following are suggested goals for brief interventions according to the client's level of consumption.

Abstainer

Even though abstainers do not require intervention, they can be educated about substance use with the aim of preventing a substance abuse disorder. Such prevention education programs are particularly important for youth.

Figure 2-2
Sample Objectives

- Learning to schedule and prioritize time
- Expanding a sober support system
- Socializing with recovering people or learning to have fun without substance abuse
- Beginning skills exploration or training if unemployed
- Attending an AA or NA meeting
- Giving up resentments or choosing to forgive others and self
- Staying in the "here and now"

Light or Moderate User

The goal of a brief intervention with someone who is a light or moderate user is to educate her about guidelines for low-risk use and potential problems of increased use. Even light or moderate use of some substances can result in health problems or, in the case of illicit substances, legal problems. These users may also engage in binge drinking (i.e., five or more drinks in a single occasion). Clients who drink should be encouraged to stay within empirically established guidelines for low-risk drinking (no more than 14 drinks per week or 4 per occasion for men and no more than 7 drinks per week or 3 per occasion for women [American Society of Addiction Medicine (ASAM), 1994]).

Brief interventions can enhance users' insight into existing or possible consequences or draw attention to the dangers associated with the establishment of an abusive pattern of substance use. For example, a woman who drinks moderately and is pregnant or who is contemplating a pregnancy can be advised to abstain from alcohol in order to prevent fetal alcohol syndrome. Brief interventions can also educate clients about the nature and dangers of substance abuse and possible warning signs of dependency. Older adults who take certain medications and use alcohol, even at this level, may be at risk for problems due to the interaction of medications and alcohol. See TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998b), for guidelines on alcohol use in older adulthood.

At-Risk User

This group includes those whose use is above recommended guidelines for alcohol use (as described above) or whose use puts them at risk for problems related to their consumption or at risk for meeting the criteria for a substance abuse disorder (e.g., people who may be able to report the requisite number of symptoms of a substance abuse disorder may not have three or more symptoms within a 12-month period). Brief interventions with this group address the level of use, encourage moderation or abstinence, and educate about the consequences of risky behavior and the risks associated with increased use. Brief interventions can help users understand the biological and social consequences of their substance use.

Abuser

These are clients with a substance abuse disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) (American Psychiatric Association [APA], 1994). The goal of intervention with this population, depending on the clinician's theoretical perspective and the substances used, is to prevent any increase in the use of substances, to facilitate introspection about the consequences of risky behavior, to encourage the client to consider assessment or treatment, and to encourage moderation or abstinence.

There is mixed evidence on whether persons who meet criteria for substance abuse can successfully reduce their use to meet lower-risk guidelines or if abstinence is the only reasonable goal. (See "Research Findings" later in this chapter for a discussion of this issue.) Both research and clinical experience have produced varying results regarding this issue. From a clinical standpoint, however, some clients who meet abuse criteria may not achieve abstinence but might benefit from a positive, nonjudgmental approach to change their behavior over time. For example, after working with a clinician to monitor problems associated with the substance abuse, a client might agree not to drive after using substances or might consider quitting.

Goals of brief interventions with hazardous drinkers who are not alcohol dependent have been flexible, allowing the individual to choose drinking in moderation or abstinence. In such cases, the goal of the intervention is to motivate

the problem drinker to change his behavior, not to assign blame. Helping clients to recognize the need for change is an essential step in this process.

Substance-Dependent User

Intervention at this level of use may focus on encouraging users to consider treatment, to contemplate abstinence, or to return to treatment after a relapse. The goal of intervention for dependent users is to recommend the optimal behavior change and level of care. In reality, however, the clinician may be able to negotiate a change the client is willing to accept and work over time toward abstinence. For example, if a client resists committing to prolonged abstinence, the provider could negotiate a limited period ending with a "checkup," at which time the client might consider extending abstinence further.

It should be noted that some substance-dependent clients may be in a life-threatening stage in their addiction or risk serious consequences such as losing their jobs, going to jail, or losing their families. For these clients, brief interventions should be linked to a referral strategy in which the goal is a therapeutic alliance between the client and the referral treatment team. Brief intervention in this context is more like "case management," in which the primary care provider tracks the client's progress with other service providers and determines if the client needs any additional services.

ASAM Criteria

Under ASAM criteria (see Figure 2-3), brief interventions are aimed at the nondependent user, at level 0.5 or possibly level I. Individuals at level II may be appropriate for a brief intervention if relapse potential and recovery environment are major problems for those with relatively minor physiological and psychological substance problems and high motivation to change. ASAM criteria have been extremely useful for clinical management of persons with substance abuse disorders who require more care than is needed for at-risk drinkers. Brief interventions, whether directed at reducing at-risk use (often used in primary care settings) or assisting in specific aspects of the treatment process, can be helpful for clients at every ASAM level and in many treatment settings.

Components of Brief Interventions

There is tremendous diversity in the process of recovery from a substance abuse disorder. Clients make changes for different reasons, and an intervention that works well for one client may not work for another. Brief interventions are components of the journey toward recovery and can be integral steps in the process. For some clients, assistance with the decision to

Figure 2-3

American Society of Addiction Medicine (ASAM) Patient Placement Criteria

ASAM has developed client placement criteria for the treatment of substance-related disorders (1996). ASAM delineates the following levels of service:

- Level 0.5, early intervention
- Level I, outpatient services
- Level II, intensive outpatient/partial hospitalization services
- Level III, residential inpatient services
- Level IV, medically-managed intensive inpatient services

make the change will be enough to motivate them to start changing the behavior, whereas others may need more intensive clinical involvement throughout the change process. Brief interventions can be tailored to different populations, and many options are available to augment interventions and treatments, such as AA, NA, and medications. It should be noted, however, that brief interventions are not a substitute for specialized care for clients with a high level of dependency. They can be used to engage clients in specific aspects of treatment programs, such as attending group and AA or NA meetings. Brief interventions can also help potential clients move toward seeking treatment and can serve as a temporary measure for clients on waiting lists for treatment programs. Even clinicians who advocate abstinence as a goal can use brief interventions as tools to help clients reach that goal.

There are six elements critical to a brief intervention to change substance abuse behavior (Miller and Sanchez, 1994). The acronym FRAMES was coined to summarize these active ingredients, which are shown in Figure 2-4. The FRAMES components have been combined in different ways and tested in diverse settings and cultural contexts.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issue in the context of the client's health
2. Screening, evaluating, and assessing
3. Providing feedback
4. Talking about change and setting goals
5. Summarizing and reaching closure

Providers may not have to use all five of these components in every session. It is more important to use the components that reflect the needs of the client and her personal style. Before eliminating steps in the brief intervention process, however, there should be a well-defined reason for doing so. Moreover, a vital part of the intervention process is monitoring to determine how the patient is progressing after the initial intervention has been completed. Monitoring allows the clinician and client to determine gains and challenges and to redirect the longer term plan when necessary.

Following are descriptions of the five basic steps. Sample scenarios are provided where brief interventions might be initiated, with practical information about that particular step. For each step, Figure 2-5 presents scripts for brief interventions that clinicians can use in substance abuse treatment units or other settings where interventions might occur. (For examples focused on at-risk drinkers, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997]. For detailed descriptions of more techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c]).

Figure 2-4
FRAMES

- **Feedback is given to the individual about personal risk or impairment.**
- **Responsibility for change is placed on the participant.**
- **Advice to change is given by the provider.**
- **Menu of alternative self-help or treatment options is offered to the participant.**
- **Empathic style is used in counseling.**
- **Self-efficacy or optimistic empowerment is engendered in the participant.**

Source: Miller and Sanchez, 1993.

Figure 2-5
Scripts for Brief Intervention

Component	Script in the emergency department, primary care office, or other setting where consultations will be performed	Script in the substance abuse treatment unit
Introducing the Issue	"I'm from the substance abuse disorder unit. Your doctor asked me to stop by to tell you about what we do on that unit. Would you be willing to talk to me briefly about it? Whatever we talk about will remain confidential." Or, "This must be tough for you. Would it be OK with you if we take a few minutes to talk about your drinking?"	"Would it be OK with you if we discuss some of the difficulties you've had in getting homework done for the group meetings and how we can work together to help you take advantage of the treatment process?"
Screening, Evaluating, and Assessing	"In reviewing the information you've given me, using a scale of 'not ready,' 'unsure,' and 'ready,' how prepared do you feel you are to stop drinking?" Client says "unsure." "One of the factors that might tie together your accident and your problems with your wife is your drinking." "I think it would be worth talking more to some of the people at the substance abuse disorder unit so that your problems don't get worse," or, "I think a 2-week trial when you don't drink alcohol at all would be helpful in determining whether or not drinking makes things worse and if stopping use works for you. What do you think?"	"Given what you see as the additional stress in your family and your desire to make the treatment work for you this time, on a scale of 1 to 10, how ready do you feel to find a way to put time into your homework?" Client says, "6." "I am pleased that you are willing to consider trying this, even though it won't be easy. Let's come up with some strategies that we can write down to help you accomplish this goal."
Providing Feedback	"I'd like to get some confidential information about your drinking to give me a better idea of your drinking style. Can you tell me how many days a week you drink? How many drinks a day?"	"I'd like to talk about what was going on when you decided not to do the homework assignment. Can you tell me a little about what you were thinking or feeling at the time? Why do you think it was difficult to get your homework done?

Figure 2-5 (continued)
Scripts for Brief Intervention

Providing Feedback (continued)	**"Have you had any problems with your health, family or personal life, or work in the last 3 months? Were you drinking in the 6 hours before your accident took place?"**	**"Have there been other parts of treatment that have been hard to follow?"**
Talking About Change and Setting Goals	"It looks as if you have been having about 30–35 drinks a week and have been doing some binge drinking on weekends. You've said that your accident took place after you'd had some alcohol, and you said you've been under a lot of stress with your family and at work. You also indicated that you don't really think alcohol is making things worse, but you're willing to think about that. Is that an accurate assessment of how you see it?"	"You've said that you completely forgot to do the homework because of arguments with your wife and daughter and that this surprised you because you had really intended to get it done. Is that about right?"
Summarizing and Reaching Closure	"Even though you're not ready to stop drinking at this time, I'm glad you agreed to write down the pros and cons of not drinking. How about if we meet tomorrow for a followup?"	"You just did a good piece of work. I think you made some progress. I'm glad you're trying something new. How about if we meet again in a week to see how things went for you?"

Introducing the Issue

In this step, the clinician seeks to build rapport with the client, define the purpose of the session, gain permission from the client to proceed, and help the client understand the reason for the intervention.

Counseling tips: Help the client understand the focus of the interview. State the target topic clearly and stress confidentiality; be nonjudgmental and avoid labels. Do not skip this opening; without it, the success of the next steps could be jeopardized.

Screening, Evaluating, And Assessing

In general, this is a process of gaining information on the targeted problem; it varies in length from a single question to several hours of assessment on the targeted topic of change. It could involve a structured or nonstructured interview or a combination of both, coupled with questionnaires or standardized instruments, with the extent of the process determined largely by the setting, time, and available resources. A sample screening guideline for alcoholism is provided in Figure 2-6. Additional information about and examples of screening and assessment instruments can be found in the following TIPS: TIP 9, *Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse*; TIP 10, *Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients*; TIP 11, *Simple Screening Instruments for Outreach for Alcohol and*

Figure 2-6
Screening for Brief Interventions for Alcoholism

Screen

At each visit, ask about alcohol use

- How many drinks per week?
- Maximum drinks per occasion in past month?

Use CAGE questions to probe for alcohol problems

- Have you ever tried to Cut down on your drinking?
- Do you get Annoyed when people talk about your drinking?
- Do you feel Guilty about your drinking?
- Have you ever had an Eye-opener? (i.e. a drink first thing in the morning)

Screen is positive if

- Consumption is greater than 14 drinks per week or greater than 4 drinks per occasion (men)
- Consumption is greater than 7 drinks per week or greater than 3 drinks per occasion (women)
- CAGE score is greater than 1

Then assess for

- *Medical problems:* blackouts, depression, hypertension, trauma, abdominal pain, liver dysfunction, sexual problems, sleep disorders
- *Laboratory:* elevated gamma-glutamyl transpeptidase or other liver function tests; elevated mean corpuscular volume; positive blood alcohol concentrations
- *Behavioral problems:* work, family, school, accidents
- *Alcohol dependence:* a score of 3 or higher on CAGE or one or more of the following: compulsion to drink, impaired control, withdrawal symptoms, increased tolerance, relief drinking

Source: ASAM, 1994; reprinted with permission.

Other Drug Abuse and Infectious Diseases; TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians*; and TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1994b, 1994c, 1994d, 1997, 1999a).

Counseling tips: Before you begin the brief intervention, decide how much information you have time to obtain and whether you want to have the client answer any questionnaires. Watch for defensiveness or other resistance, and avoid pushing too hard.

Providing Feedback

This component highlights certain aspects of the client's behavior using information gathered during screening. It involves an interactive dialog for discussing the assessment findings; it is not just clinician driven. Feedback should be given in small amounts. First, the clinician gives a specific piece of feedback, then asks for a response from the client. Sometimes the feedback is a brief, single sentence; at other times it could last an hour or more. Figure 2-7 provides an example of giving feedback.

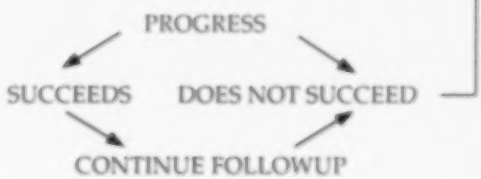
Counseling tips: Use active listening (see "Active listening" later in this chapter). Be aware of cultural, language, and literacy issues. Be nonjudgmental.

Figure 2-7
Client Feedback and Plan of Action

Give specific feedback to the patient, then advise in a firm but empathic manner

If diagnosed as at risk:

- Advise patient of risk
- Advise abstinence or moderation
- Set drinking goals
- Schedule followup to discuss progress



If diagnosed as alcohol dependent:

- Advise patient of objective evidence
- Advise on plan of action
- Assess acute risk of intoxication or withdrawal
- Medical and psychiatric comorbidities
- Agree on plan of action

Plan of Action

- Involve family: refer for family treatment and self-help (e.g., Al-Anon, etc.) (must have patient permission and involvement)
- Stress abstinence
- Urge patient to attend self-help meetings (AA, NA, Self-Management and Recovery Training [SMART], etc.)
- Consider referral to addiction medicine specialist, and/or possible pharmacotherapy with disulfiram (Antabuse) or naltrexone (ReVia)

Source: ASAM, 1994; reprinted with permission.

Talking About Change And Setting Goals

Talking about change involves talking about the possibility of changing behavior. It is used with clients in all stages of change, but it differs profoundly depending on the stage the client has reached. For example, in precontemplation, clients are helped to recognize and change their view of consequences; in contemplation, they are helped to resolve ambivalence about change. In action, the focus is on planning, removing barriers, and avoiding risky situations; in maintenance, the emphasis is on establishing new long-term behaviors. It is important that the clinician assess the client's readiness to change if it is not already known. (See Figure 2-8 for examples of discussing change with a client who is trying to stop using cocaine but wants to continue to drink alcohol.)

In talking about change, the clinician often suggests a course of action, then negotiates with the client to determine exactly what he is willing to do. Sometimes, talking about change is premature (i.e., before the assessment and feedback have happened). In that case, it should be postponed until later in the intervention.

Counseling tips: Offer change options that match client's readiness for change. Be realistic: Recommend the ideal change, but accept less if the client is resistant.

Summarizing and Reaching Closure

This step involves a summary of the discussion and a review of the agreed-upon changes.

Figure 2-8

Talking About Change at Different Stages

In this example, a client who has come to treatment to stop using cocaine has her alcohol use brought to her attention. At each stage of readiness, the counselor might use a different strategy. Following are some of the possible scripts that might be used:

- *Precontemplation:* "Some people find it helpful to ask others in a group if any of them tried to quit cocaine but continued drinking. If you were to try that with your group, you might be surprised at what you hear. What do you think?"
- *Contemplation:* "One thing you might try is writing a list of the pros and cons of stopping drinking, as you see them. Just write down all the ideas that come to you, no matter how silly or offbeat they seem. This may help you get a clearer picture of your situation. Is that something you'd be willing to try?"
- *Action:* "You've said you want to try quitting alcohol, as well as cocaine. Can we talk about how you might go about making that happen?"
- *Maintenance:* "Things have improved in a lot of ways for you. I'd like to meet with you each month for a while to talk about what things work for you and what things don't work as well." (Because relapse can occur at any point in the change process, addressing this issue in a proactive, positive manner is useful.)

If no agreement was reached, review the positive action the client took during the session. At this point, it is important to schedule a followup visit to talk about how the client is progressing. The followup could be another face-to-face meeting, a telephone call, or even a voice mail message. The goals of closing on good terms are to arrange another session, to leave the client feeling successful, and to instill confidence that will enable the client to follow through on what was agreed upon

Counseling tips: Tailor your closure to the client and the particular circumstance of this brief intervention; interpret any client resistance in a positive light leading to progress. Thus, if a client has been unwilling to commit to changes, thank her for her willingness to consider the issues and express the hope that she will continue to consider committing to changes.

Brief Intervention Workbooks

Brief intervention protocols often involve using a workbook that is based on the steps listed below. A workbook provides the client and clinician with opportunities to discuss the client's cues for using substances, reasons for using substances, and reasons for cutting down or quitting. It also usually provides a substance abuse agreement in the form of a prescription and substance abuse diary cards for self-reporting. These techniques, which often target reduction in substance abuse rather than abstinence, are similar to homework techniques used in substance abuse treatment programs. A sample of a workbook used to address drinking problems is provided in Appendix D. The steps

in the workbook follow a script and may focus on the following:

- Identification of future goals for health, activities, hobbies, relationships, and financial stability
- Customized feedback on screening questions relating to substance abuse patterns and other health habits (also may include smoking, nutrition, etc.)
- Discussion of where the client's substance abuse patterns fit into the population norms for his age group
- Identification of the pros and cons of substance abuse—this is particularly important because the clinician must understand the role of substance abuse in the context of the client's life (given the opportunity to discuss the positive aspects of her substance abuse, the client may talk about her concerns honestly instead of feeling she should say what she thinks the clinician wants to hear; this builds a better working relationship)
- Consequences of continued substance use to encourage the client to decrease or stop abusing substances and avoid longer term effects of continued substance abuse
- Reasons to cut down or quit using (maintaining family, work, independence, and physical health all may be important motivators)
- Sensible use limits and strategies for cutting down or quitting—useful strategies include developing social opportunities that do not involve abusing substances and becoming reacquainted with hobbies and interests
- A substance abuse agreement—agreed-upon use limits (or abstinence) signed by the client and the clinician—can often be an effective way to alter use patterns
- Coping with risky situations (e.g., socializing with substance users, isolation, boredom, and negative family interactions)
- Summary of the session

Essential Knowledge and Skills for Brief Interventions

Providing effective brief interventions requires knowledge, skills, and abilities. Studies have shown that applying the clinician's skills listed below produces good outcomes, including getting clients to enter treatment, work harder in treatment, stay longer in treatment, and have better outcomes after treatment such as higher participation in aftercare and better sobriety rates (Brown and Miller, 1993; Miller et al., 1993).

- Overall attitude of understanding and acceptance
- Counseling skills such as active listening and helping clients explore and resolve ambivalence
- A focus on intermediate goals (see discussion earlier in this chapter)
- Working knowledge of the stages-of-change model (see discussion earlier in this chapter)

Attitude of Understanding And Acceptance

Clinicians must assure their clients that they will listen carefully and make every effort to understand the client's point of view during a brief intervention. Brief interventions are by definition time limited, which increases the difficulty of adopting such an attitude. However, when clients experience this nonjudgmental, respectful interest and understanding from the clinician, they feel safe to openly discuss their ambivalence about change—rather than resist pressure from the clinician to change before they are ready to do so. The sooner they address their ambivalence, the sooner they progress toward lasting change (see also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c]).

When clients feel they are being pushed toward change—even if the clinician is not pushing—they are likely to resist. Clients must summon all of their attention and strength to resolve their ambivalence, and resisting the clinician may cause them to lose track and argue against change. If the client and clinician begin arguing or debating, the clinician should immediately shift to a new strategy, otherwise the brief intervention will fail. In other words, resistance is a signal for the clinician to change strategies and defuse the resistance.

Counseling Skills

Active listening

One of the most important skills for brief interventionists is "active listening" (see Figure 2-9). Active listening is the ability to accurately restate the content, feeling, and meaning of the client's statements. This is also called "reflective listening," "reflecting," or sometimes "paraphrasing." Active listening is one of the most direct ways to rapidly form a therapeutic alliance. When done well, it is a powerful technique for understanding and facilitating change in clients. Active listening goes beyond nonverbal listening skills or responses such as, "Hmmm," "Uh-huh," "I see," "I hear you," or "I understand where you're coming from." None of these short statements demonstrates that the clinician understands. Counselors should also ask open-ended questions to which the client must respond with a statement, rather than a simple yes or no. Instead of summarizing a situation and then asking, "Is this correct?" ask the client, "What do you think? How do you feel about the situation?" Open-ended questions are invitations to share and provide a means to probe for important information that emerges in the interview.

Exploring and resolving ambivalence

Another important skill is the ability to help clients explore and resolve ambivalence. Ambivalence is the hallmark of a person in the contemplation stage of readiness. It is one of the most prevalent clinical challenges encountered in brief interventions. Whether it takes 1 minute or 40 minutes, the goal is to help clients become more aware of their position and the discomfort that accompanies their ambivalence. Increasing awareness of this discomfort within an understanding and supporting relationship can inspire the client to progress to a stage of preparation or action. For example, a client might be willing to go to counseling but not an AA meeting; in that case, the clinician should work with the client's motivation and focus on the positive step the client is willing to make.

One way to help a client recognize his ambivalence is to ask him to identify the benefits and costs of the targeted behavior (e.g., using alcohol) and the benefits and costs of changing

Figure 2-9
Steps in Active Listening

1. *Listen* to what the client says.
2. *Form a reflective statement.* To reflect your understanding, repeat in your own words what the client said.
3. *Test the accuracy of your reflective statement.* Watch, listen, and/or ask the client to verify the accuracy of the content, feeling, and/or meaning of the statement.

Skilled active listeners perform these three steps automatically, naturally, smoothly, and quickly. Active listening saves time by reducing or preventing resistance, focusing the client, focusing the clinician, encouraging self-disclosure, and helping the client remember what was said during the intervention.

the behavior. The clinician listens and summarizes these benefits and costs, then asks the client if any of them is more important than the others. This helps identify values that are important to the client and can therefore increase or decrease the chance of changing. Clinicians might also ask if any of the pros and cons is more or less accurate than others. This provides an opportunity for irrational thoughts to be refuted, which can help remove barriers to change (see example in the text box below).

Another approach to raising awareness of ambivalence is to explore the client's experience of feeling caught between opposing desires. For more specific techniques for resolving ambivalence, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999c).

Brief Interventions in Substance Abuse Treatment Programs

Substance abuse treatment programs frequently use brief interventions, although they might not be called by that name. Brief interventions can be effectively integrated into more comprehensive treatment plans for clients with substance abuse disorders. These approaches can be particularly useful in treatment settings when they are used to address specific targeted client behaviors and issues in the treatment process that can be difficult to change using standard treatment approaches. Brief interventions can be used with clients before, during, and after substance abuse treatment.

To integrate the use of brief interventions into specialized treatment, counselors and providers should be trained to provide this service. The Consensus Panel recommends that agencies consider allocating counselor training time and resources to these modalities. The Panel anticipates that brief interventions will help agencies meet the increasing demands of the managed care industry and fill the gaps that have been left in client care. It is also extremely important for substance abuse treatment personnel to collaborate with primary care providers, employee assistance program (EAP) personnel, wellness clinic staff, and other community-based service providers in developing plans that include both brief interventions and more intensive care to help keep the client focused on treatment and recovery. The following is a list of the potential benefits of using brief interventions in substance abuse treatment settings:

- Reduce no-show rates for the start of treatment
- Reduce dropout rates after the first session of treatment
- Increase treatment engagement after intake assessment
- Increase compliance for doing homework
- Increase group participation
- Address noncompliance with treatment rules (e.g., smoking in undesignated places, unauthorized visits, or phone calls)

Removing a Barrier to Change

Your client, Mary, is hospitalized because of an alcohol-related injury. You conduct a brief intervention in the hospital. During the session, she says that one of the good things about her drinking is that she "always had fun when she was drinking." In that case, you can ask her what her perspective is on the situation and whether she sees a connection between her drinking and her current behavior. This could lead to her challenging one of her reasons for drinking. By systematically exploring the reasons for and against drinking, you can help her tip the scale in favor of change.

- Reduce aggression and violence (e.g., verbal hostility toward staff and other clients)
- Reduce isolation from other clients
- Reduce no-show rates for continuing care
- Increase mutual-help group attendance
- Obtain a sponsor, if involved with a 12-Step program
- Increase compliance with psychotropic medication therapies
- Increase compliance with outpatient mental health referrals
- Serve as interim intervention for clients on treatment program waiting lists

Brief Interventions Outside Substance Abuse Treatment Settings

Brief interventions are commonly administered in nonsubstance abuse treatment settings, often referred to as opportunistic settings, where clients are not seeking help for a substance abuse disorder but have come to receive medical treatment, to meet with an EAP counselor, or to respond to a court summons (see Figure 2-10 for a list of health care and other professionals who often conduct brief substance use interventions). These settings and many others provide a multitude of opportunities to help people change their substance abuse patterns. It is unrealistic and unnecessary for providers in opportunistic settings to avoid working with people with a range of substance abuse problems including substance abuse disorders and merely to refer them for specialty care (Miller et al., 1994). Many clients do not use alcohol, for example, at a level that requires specialized treatment. Others who use at moderate or severe levels may be unwilling or unable to participate in specialized, mainstream substance abuse treatment programs. Moreover, some individuals may attach a stigma to attending treatment versus general health care services. Older adults and women often do not seek or engage in treatment because of stigma.

An individual's level of substance use is detected through screening instruments, medical tests (e.g., urine testing), observation, or simply asking about consumption patterns. Those considered to have risky or excessive patterns of substance abuse or related problems can receive a brief intervention that rarely requires more than several sessions, each lasting only 5 minutes to 1 hour (average = 15 minutes).

The goal of a brief intervention is to raise the recipient's awareness of the association between the expressed problem and substance abuse and to recommend change, either by natural, client-directed means or by seeking additional substance abuse treatment. Because the recipient usually does not expect to have a substance abuse problem identified, he may or may not be motivated to apply any recommendations. The brief intervention is highly structured and focuses on delivering a message about the individual's substance abuse

Figure 2-10
Professionals Outside of Substance Abuse Treatment Who Can Administer Brief Interventions

- Primary care physicians
- Substance abuse treatment providers
- Emergency department staff members
- Nurses
- Social workers
- Health educators
- Lawyers
- Mental health workers
- Teachers
- EAP counselors
- Crisis hotline workers, student counselors
- Clergy

and advice to reduce or stop it. If the initial intervention does not result in substantial improvement, the professional may refer the individual for additional specialized substance abuse treatment.

Treatment providers who work in settings other than substance abuse treatment must be flexible when assessing, planning, and carrying out brief interventions. For example, they will likely encounter more risky drinkers than alcohol-dependent individuals (in the United States there are four times as many risky drinkers as dependent drinkers [Mangione et al., 1999]). Some research indicates that the potential for brief interventions to reduce the harm, problems, and costs associated with moderate to heavy alcohol use by risky drinkers significantly surpasses the effectiveness from applications of brief interventions on substance-dependent individuals (Higgins-Biddle et al., 1997). Other research on brief interventions, as presented below, highlights some of the more rigorous studies with positive outcomes. The costs of alcohol abuse to society, as interpreted by health care costs, lost productivity, and criminal activity, are enormous, and brief interventions are a cost-effective technique to address such abuse. Typically these brief interventions act as an early intervention before or close to the development of alcohol-related problems and primarily entail instructional and motivational components addressing drinking behavior. In substance abuse treatment, brief interventions are used to assist in the treatment engagement process and to deal with specific individual, family, or treatment-related issues.

When delivering a brief intervention in any treatment setting, the provider should be mindful of room conditions and interruptions because client confidentiality is of utmost importance. Federal law requires that chart notes or other records on substance abuse be kept apart from the rest of the client's main chart. For example, if a medical client in a primary care clinic is also seen by an alcohol and drug counselor for treatment of a substance abuse disorder, those medical records are strictly protected by Federal law and may not be put in the client's chart. (For more information on these Federal laws, see TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997].)

Heather makes an important distinction between brief interventions that are delivered in opportunistic settings where patients are not directly seeking help for a substance abuse disorder and those conducted in treatment environments where patients are seeking the help of specialists (Heather, 1995). Brief interventions conducted in opportunistic settings tend to be shorter, rely less on theory and more on an existing clinician–client relationship, and are less expensive because they are offered as part of an existing service.

Conducting Brief Interventions With Older Adults

Older adults present unique challenges in applying brief intervention strategies for reducing alcohol consumption. The level of drinking necessary to be considered risky behavior is lower than for younger individuals (Chermack et al., 1996). Intervention strategies should be nonconfrontational and supportive due to increased shame and guilt experienced by many older problem drinkers. As a result, older adult problem drinkers find it particularly difficult to identify their own risky drinking. In addition, chronic medical conditions may make it more difficult for clinicians to recognize the role of alcohol in decreased functioning and quality of life. These issues present barriers to conducting effective brief interventions for this vulnerable population. For more on this topic, refer to TIP 26, *Substance Abuse Among Older Adults* (CSAT, 1998b).

Research Findings

Brief interventions for substance abuse have been implemented since the 1960s. The literature in this area includes theoretical articles, clinical case studies and recommendations, quasi-experimental studies, and randomized controlled experimental research trials. Many of the brief intervention clinical trials have been conducted in the United States and Europe since the early 1980s, and most have focused on alcohol use. There is some experimental research on brief interventions for drug use but very little has been published to date. This is an area of ongoing and future work.

Reviews of Brief Intervention Studies

A 1995 review article (Kahan et al., 1995) sorted through 43 relevant articles found in MEDLINE published from 1966 to 1985 and 112 in EMBASE published from 1972 to 1994. Another, more recent review (Wilk et al., 1997) culled nearly 6,000 articles from MEDLINE and PsychLIT searches from 1966 to 1995 to find 99 that met criteria for closer inspection. A total of 11 of the articles found by Kahan and colleagues and 12 of those reviewed by Wilk and associates had control groups, adequate sample sizes, and specified criteria for brief interventions.

The most recent reviews of brief intervention studies concluded that brief interventions have merit, especially for carefully selected clients and can be applied successfully in several settings for different purposes (Bien et al., 1993; Kahan et al., 1995; Mattick and Jarvis, 1994; Wilk et al., 1997). The review by Bien and colleagues was one of the first to categorize brief interventions and evaluate their effectiveness according to the stated goals and settings in which they were conducted. After examining 12 controlled studies of strategies to improve clients' acceptance of referrals for additional specialist treatment or return to the clinic for additional treatment following an initial visit, Bien and colleagues concluded that relatively simple strategies and specific aspects of counselors' styles can increase rates of followthrough on referrals as well as improve initial engagement and participation in treatment (Bien et al., 1993). Only one unsuccessful trial of referral procedures is described, and the failure is attributed to the fact that all subjects had previously failed to respond to brief advice about getting into treatment for alcoholism.

Bien and colleagues also examined 11 well-conducted trials of brief interventions for excessive drinkers identified in health care settings (including the large-scale, 10-nation World Health Organization [WHO] study) (Bien et al., 1993). They found that eight of the studies showed significant reductions in alcohol consumption levels and/or associated problems for the subjects receiving brief, drinking-focused interventions in comparison with those receiving no counseling. Three other studies found no significant differences between experimental and control groups at followup, although drinking levels and other problem measures were reduced in both groups. Bien and colleagues concluded that it is better for health care providers in opportunistic settings such as primary care to intervene in a nonjudgmental motivational format than it is to provide no intervention to patients who did not expect to have their drinking patterns evaluated.

In addition, these authors also reviewed 13 randomized clinical trials comparing brief interventions to a range of more extensive therapies in specialized alcohol treatment settings and found that shorter counseling was, with remarkable consistency, comparable in impact to more traditional approaches in yielding specified outcomes (Bien et al., 1993). Only two studies reported an advantage of more extensive treatment over brief interventions on

some outcome measures. They concluded that no evidence supports the inferiority of brief interventions in comparison with more extensive treatment offered by treatment specialists to patients who are seeking help for their alcohol-related problems. Heather argues, however, that the findings do not support the statement that the effectiveness of brief interventions is equal to that of other studied treatments for alcohol abuse (Heather, 1995).

Finally, Bien and colleagues concluded from an analysis of three other studies that brief interventions enhanced the motivation of treatment-seeking problem drinkers to enter and remain in outpatient or residential alcohol treatment compared with clients not receiving such attention (Bien et al., 1993).

Although other reviewers of brief interventions have reported more qualified reactions, all seem to agree that strong research evidence supports the use of brief interventions for heavy or excessive, nondependent drinkers, particularly those identified in general medical practice settings (Heather, 1995; Kahan et al., 1995; Mattick and Jarvis, 1994; Wilk et al., 1997). Wilk and colleagues examined evidence from 12 controlled clinical trials that randomized nearly 4,000 heavy drinkers to brief intervention or no intervention (Wilk et al., 1997). They concluded that heavy drinkers who received interventions in a primary care setting were almost twice as likely to moderate drinking than those who did not receive an intervention. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has also presented data on the efficacy and uses of brief interventions for dependent drinkers (NIAAA, 1999).

This TIP reviews the most methodologically sound brief intervention studies and discusses methodological limitations of previous and current research in this area. The research is presented in two sections: (1) brief interventions for at-risk and problem use and (2) brief interventions for substance abuse.

Brief Interventions for At-Risk And Problem Use

A study conducted in 1983 focused on males in Malmo, Sweden, in the late 1970s (Kristenson et al., 1983). The subjects, advised to reduce their alcohol use in a series of health education visits, subsequently demonstrated significant reductions in gamma-glutamyl transferase levels and health care utilization up to 5 years after the brief interventions. The Medical Research Council (MRC) trial, conducted in 47 general practitioners' offices in Great Britain (Wallace et al., 1988), found significant reductions in alcohol use by the intervention group compared to the control group 12 months following the intervention.

Anderson and Scott identified men and women from eight general practices in England who consumed more than 15 standard drinks (for men) or 9 standard drinks (for women) of alcohol per week (Anderson and Scott, 1992). These individuals were randomly assigned to receive either no intervention or feedback about the findings from the screening and 10 minutes of advice from the physician to reduce their consumption levels, accompanied by a pamphlet of self-help information. After 1 year, the males in the advice group had significantly reduced their mean weekly alcohol consumption by 2.8 ounces more than those who received no intervention. The females in both groups, however, showed significant reductions in alcohol consumption at the same followup point, with no between-group differences.

In a widely publicized evaluation of brief interventions conducted in health care settings in 10 nations sponsored by WHO, the investigators identified 1,490 nonalcoholic heavy drinkers from eight core sites through a 20-minute health interview (Babor and Grant, 1991; Babor et al., 1994). These participants were randomly assigned to one of four groups: (1) no further intervention, (2) 5 minutes of simple

advice about the importance of sensible drinking or abstinence, (3) simple advice plus 15 minutes of brief counseling and a self-help manual that encouraged the development of a habit-breaking-plan, or (4) at five of the sites, extended supportive counseling delivered in three extra sessions following the initial advice and 15-minute session. After 9 months, males who received any intervention, including the 5 minutes of advice, reported approximately 25 percent less daily alcohol consumption—a greater change than was observed in the no-intervention control group. Significantly, the men who showed the greatest response to simple advice had more severe alcohol problems and higher consumption patterns.

Another interesting finding from the WHO study was that female participants in all groups had reduced their drinking at 9 months, regardless of whether they received any intervention. One explanation may be that the female participants were only recruited from two relatively affluent countries—Australia and the United States—thus, the results cannot be generalized to all women (Sanchez-Craig, 1994). Furthermore, the 20-minute comprehensive assessment was sufficiently intensive that some women may have responded to implicit messages of cutting down on consumption without further overt advice, especially considering that only 10 minutes of simple advice or 15 minutes of counseling were additionally provided (Kristenson and Osterling, 1994).

One successful study demonstrated the efficacy of a brief alcohol intervention in a community-based primary care setting (Fleming et al., 1997). Project TrEAT (Trial for Early Alcohol Treatment) identified 723 men and women as problem drinkers from 17,695 patients who were screened in 17 community-based primary care practices. The outcomes studied were reductions in alcohol consumption and health resource utilization. In comparison with a no-intervention control group, the patients who received two 10- to 15-minute sessions of scripted advice (using a workbook that focused on advice, education, and contracting information) showed significantly greater reductions in alcohol consumption at a 12-month followup based on drinking levels during the previous week, episodes of binge drinking over the past month, and frequency of excessive drinking in the previous 7 days. Males in the study also had significantly fewer days of hospitalization than counterparts in the control group. Females in the experimental groups reduced their consumption significantly more than males in the experimental group. This research group (Fleming et al., 1999) also conducted a similar trial with primary care patients over 65 and found significant differences in drinking after 12 months for the experimental group compared to the control group.

Miller and colleagues have developed a special form of a brief intervention known as the Drinker's Check-Up (Miller and Sovereign, 1989), designed to evaluate whether alcohol is harming an individual in any way. In the 1989 study, participants were recruited through media advertisements and were asked to come into a neutral setting for the assessment. As reported by Bien and colleagues, several trials of this approach have demonstrated encouraging results from providing systematic feedback about assessment results and some self-help options (Bien et al., 1993). Compared with a no-intervention group of respondents who had to wait 6 weeks for assessment, the recipients of immediate feedback and brief, empathic assistance showed prompt and persistent reductions (of 29 to 57 percent) in consumption patterns. More empathic counseling, an important component of brief interventions (see discussion on FRAMES earlier in this chapter), is also associated with larger reductions than the

use of the more traditional confrontational styles (Miller et al., 1993).

While the types of brief interventions vary, the basic design of most studies is a randomized controlled trial that assigns clients with hazardous drinking patterns either to a brief intervention (ranging from one to ten sessions) or to one or more control conditions (Anderson and Scott, 1992; Babor, 1992; Babor and Grant, 1991; Chick et al., 1985; Fleming et al., 1997; Harris and Miller, 1990; Heather et al., 1987; Kristenson et al., 1983; Persson and Magnusson, 1989; Wallace et al., 1988). Overall, the majority of brief alcohol intervention studies have found significantly greater improvements in drinking outcomes for the experimental group compared to the control group; however, most also found significant changes in drinking over time for both the control and brief intervention conditions. Meta-analyses found an effect size of 20 to 30 percent in studies conducted in health care settings (Bien et al., 1993; Kahan, 1985). Trials conducted since 1995 have garnered similar effect sizes with one trial finding a greater effect size for women (35 percent) (Fleming et al., 1997). Women were not always included in earlier trials, but later trials that did include women found that they were more likely than men to decrease their drinking based on brief targeted advice.

Because of the success of brief alcohol interventions with adults in opportunistic settings, new trials with special populations (e.g., older adults, injured patients in emergency departments, pregnant women) are now being proposed and conducted. In addition, new technologies are being studied, including computerized real-time tailored booklets for at-risk drinkers, and the use of Interactive Voice Recognition (IVR) for interventions and followup. These and other technologies, if efficacious and effective, will provide clinicians with new tools to assist them in working with a difficult and important clinical and public health issue.

Brief Interventions for Dependent Use

Most studies of brief interventions for alcohol use that had the goal of changing drinking behavior have included only subjects who did not meet criteria for alcohol dependence and explicitly excluded dependent drinkers with significant withdrawal symptoms. The rationale for this practice was that alcohol-dependent individuals or those affected most severely by alcohol should be referred to formal specialized alcoholism treatment programs because their conditions are not likely to be affected by low intensity interventions (Babor et al, 1986; Institute of Medicine [IOM], 1990). However, there have been positive trials that address this issue specifically.

NIAAA reviewed the studies focused on alcohol-dependent drinkers (NIAAA, 1999). Some of these studies focused on the effectiveness of motivating alcohol-dependent patients to enter specialized alcohol treatment. As long ago as 1962, a nonrandomized study was conducted of alcohol-dependent patients, identified in the emergency department (Chafetz et al., 1962). Of those receiving brief counseling, 65 percent followed through in keeping a subsequent appointment in a specialized alcohol treatment setting. Only 5 percent in the control group followed through with an appointment.

Brief interventions have also been compared to more intensive and extensive treatment approaches used in traditional treatment settings with positive results (Edwards et al., 1977; Project MATCH Research Group, 1997, 1998). In a small study, the effectiveness of a one-session brief advice protocol plus monthly followup telephone calls, focused on the patient's personal responsibility to stop

drinking, was compared to standard alcohol treatment for 100 men who were alcohol dependent (Edwards and Orford, 1977). At 1-year followup both groups reported a 40 percent decrease in alcohol-related problems. The study found, at 2-year followup, that the patients with the less severe alcohol problems did best in the brief intervention group. The patients with more serious alcohol-related problems did best in intensive alcohol treatment (Orford et al., 1976).

Several similar studies conducted in New Zealand (Chapman and Huygens, 1988), London (Drummond et al., 1990), the United States (Miller et al., 1980, 1981; Miller and Munoz, 1982), and Norway (Skutle and Berg, 1987) essentially replicated the results of previous positive trials, comparing brief interventions favorably with a variety of extended treatments for problem drinking (including cognitive–behavior therapies, marital therapy, confrontational counseling, and standard inpatient and outpatient treatment).

Sanchez-Craig and colleagues found that when comparing the 12-month treatment outcomes of severely dependent and nonseverely dependent men receiving brief treatment in Toronto and Brazil, there were no significant differences in "successful" outcomes as measured by rates of abstinence or moderate drinking (Sanchez-Craig et al., 1991). The IOM also noted that rates of spontaneous remission of alcoholism suggest that some portion of the most severe alcoholic population will reduce or discontinue their drinking without formal intervention (IOM, 1990).

The largest multisite NIAAA-sponsored study of treatment matching and outcomes, Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity), compared the effects of treatment type on outcomes for more than 1,500 alcohol-dependent patients (Project MATCH Research Group, 1997, 1998). Treatment types included (1) four 1-hour sessions of motivational enhancement therapy, which is often considered a brief intervention even though it is more intensive than most brief interventions (NIAAA, 1995), (2) 12 sessions of 12-Step facilitation, and (3) 12 sessions of cognitive–behavioral coping skills therapy. At 1- and 3-years postintervention, all three groups reported improvements including drinking less often and drinking fewer drinks per day.

A small successful application of a brief motivational intervention within a substance abuse treatment setting administered approximately 1 hour of motivational interviewing for problem drinkers (adapted from Miller and Sovereign, 1989) to seriously opiate-dependent clients recently admitted to a methadone maintenance clinic (Saunders et al., 1995). Fifty-seven clients were randomized to the experimental group and were asked to identify positive and negative aspects of their opiate use and to project the consequences into the future. These clients were then asked to think about their use and discuss it at the 1-week followup session. The 65 subjects in the control group received a 1-hour educational intervention covering six substance-related issues such as overdose responses, legal aspects, and referral sources. Followup sessions were held with both groups at 1 week, 3 months, and 6 months. Significantly fewer clients receiving the motivational intervention dropped out of the study at each of the followup points compared with those receiving the educational component. By the 6-month point, the motivational subjects had significantly fewer opiate-related problems than the others. In comparison with the educational group, the clients receiving the motivational intervention were also more likely to make a positive initial shift on a stage-of-change measure (see the discussion of stages-of-change earlier in this chapter), express a stronger commitment to abstinence, remain in treatment longer, and relapse less quickly if they did drop out. The study concluded that brief

motivational interventions strengthened recipients' resolution to abstain from opiate use and participate fully in treatment, and were therefore useful in improving performance and program compliance among clients attending a methadone clinic (Saunders, 1995). This and other studies have found that compliance with a treatment plan, rather than simply length of treatment, is one of the important factors influencing positive outcomes for clients receiving treatment.

In a study looking at the costs of brief interventions, Holder and colleagues evaluated the evidence of clinical effectiveness and the typical costs of various alcoholism treatment modalities and found brief motivational counseling among the most effective in terms of a combination of clinical and cost effectiveness (Holder et al., 1991). It ranked third among the six highest ranking approaches in terms of weighted effectiveness (based on a total of nine studies conducted between 1983 and 1990). Brief motivational counseling was also rated the least costly of the six most effective modalities—or most cost-effective of 33 evaluated modalities. The authors of this study specifically stated that treatment planning and funding decisions should not be based on this initial effort to make "first level approximations" of cost-effectiveness.

Critics have raised concerns that brief interventions could be construed as a treatment panacea for all patients with varying levels of alcohol-related problems and different consumption patterns (Drummond, 1997; Heather, 1995; Mattick and Jarvis, 1994). Although most researchers acknowledge that many clients do not need a protracted and expensive course of individual or group treatment, the literature advocating brief interventions as a treatment for all substance abuse is overstated (Heather, 1995; Mattick and Jarvis, 1994). Caution always needs to be employed in evaluating study recommendations. The clinical trials in this TIP on the use of brief interventions have been specific regarding the targeted population tested and the level of generalizability possible.

Methodological Issues

Issues are frequently raised regarding specific methodological concerns of studies on brief interventions. First, many of the brief intervention studies, particularly those focused on alcohol, rely on self-report data to determine outcomes. The validity of measuring alcohol and other use by self-report is routinely questioned; however, reviewers of relevant literature have concluded that these data are generally valid and reliable (Midanik, 1982; Sobell and Sobell, 1990). Reports from collaterals, such as family members, are not as reliable except for highly visible events, such as drinking-related arrests (Midanik, 1982). Persons with hazardous drinking patterns will provide accurate information about their use, particularly under the following conditions: (1) the setting is a research or clinical one, (2) confidentiality is assured, and (3) the interview is administered when the respondent is sober (Sobell and Sobell, 1990). Techniques to increase the accuracy of self-reports have been employed in recent studies (Fleming et al., 1997, 1999). These studies use interviewers who fully understand drinking-related questions and can explain confusion about common terms (e.g., "blackouts," "high").

Concerns about the methodological limitations of some trials have included sample sizes that were too small and a statistical power insufficient to reliably detect differences between effects in the groups compared (Bien et al., 1993; Mattick and Jarvis, 1994). There may be differential attrition in groups at followup, and these dropouts can be ignored or excluded from analyses (Bien et al., 1993; Drummond, 1997; Kahan et al., 1995), or there could be contamination because the comparison group

could be seeking additional treatment during the course of the research (Bien et al., 1993; Kahan et al., 1995; Mattick and Jarvis, 1994). Also, randomization of samples has not always been conducted (Wilk et al., 1997), and some early studies did not have control groups or did not have an adequate comparison group (Bien et al., 1993). Some of the newer brief intervention studies have addressed many of these concerns (Fleming et al., 1997, 1999). These, however, remain issues that must be addressed by new studies of brief intervention techniques with special populations and with new technology.

Future Issues in Research and Practice

The background research in this TIP is based on the most rigorous trials from the 1960s through the 1990s. As study designs have become more sophisticated, many of the earlier methodological issues are being addressed. Questions remain regarding specific levels of abuse and dependence after which brief intervention approaches are less effective and more intensive treatment is required. It is possible that factors such as social stability and support (as indicated in Edwards and Orford, 1977) play a role in improved responses to briefer treatments and that these factors may be more important than the level of substance abuse or dependence.

As secondary analyses are conducted from more recent clinical trials, some of the strongest covariates will emerge. Further research focused specifically on the myriad of issues that could affect outcomes is needed to determine whether brief interventions can be useful for clients with dual diagnoses or whether they always require more intensive treatments because of the complexity of their illnesses. Although there is ongoing research testing the effectiveness of brief interventions with patients who have serious psychiatric illnesses and coexisting substance abuse disorders, there are no published studies that definitively address this issue.

There is strong evidence supporting the efficacy of alcohol screening and brief interventions, in particular (Fleming et al., 1997). However, few studies to date have tested the implementation of brief intervention strategies in community-based medical and treatment settings. Several new initiatives address this critical next step in the process. Higgins-Biddle and colleagues identified the research base and current applications of screening and brief interventions (Higgins-Biddle et al., 1997). The findings on the effectiveness from clinical trials on screening and brief interventions were found to be encouraging, with risky drinkers reducing their alcohol consumption by 20 percent, on average. Individual study results varied from 15 to 40 percent depending on the population and methodology used. In the next few years, focused work in these areas will inform clinicians regarding optimal brief intervention implementation strategies and provide a bridge from research efficacy to practical application in real world clinical settings.

There is evidence that a variety of brief interventions are effective with at-risk and hazardous substance users, and emerging evidence suggests that brief interventions can be used to motivate patients to seek specialized substance abuse treatment and to treat some alcohol-dependent persons. Clinical evidence also suggests that brief interventions can be used in specialized treatment programs to address specific targeted issues.

In sum, the Consensus Panel believes it is critical for policymakers and providers of managed care to understand that brief interventions should never be thought of as the only treatment option for persons with substance abuse problems but as one of a continuum of techniques for use with a population of clients with substance abuse problems ranging from at-risk to dependent use.

3 Brief Therapy in Substance Abuse Treatment

Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. Brief therapy providers can effect important changes in client behavior within a relatively short period. The brief therapies presented in this TIP should be seen as contained modalities of treatment, not episodic forms of long-term therapy.

However, in the literature and in practice, the term "brief therapy" covers a wide range of approaches to treatment of varying lengths and with a variety of goals. Brief therapies usually consist of more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 session (Bloom, 1997) to 40 sessions (Sifneos, 1987), with the typical therapy lasting between 6 and 20 sessions. Twenty sessions usually is the maximum because of limitations placed by many managed care organizations. Any therapy may be brief by accident or circumstance, but the focus of this TIP is on *planned* brief therapy. The therapies described here may involve a set number of sessions or a set range (e.g., from 6 to 10 sessions), but they always work within a time limitation that is clear to both therapist and client. In the following pages, all therapies described should be understood as planned or time limited.

Brief therapies differ from brief interventions in that their goal is to provide clients with tools to change basic attitudes and handle a variety of underlying problems. Compared with brief therapies, brief interventions are more motivational, seeking to motivate the client to make a specific change (in thought or action). (See Chapter 1 for more on how this TIP distinguishes brief therapies from brief interventions.)

Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes using effective therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change. A number of specific types of therapy are designed to be carried out in a brief period (e.g., cognitive–behavioral approaches are often designed to require fewer than 20 sessions). Many longer approaches have been or can be adapted; even lengthy psychodynamic approaches have been adapted for brief therapy with clear guidelines for their use (Davanloo, 1980; Luborsky, 1984; Mann, 1973; Sifneos, 1972; Strupp and Binder, 1984).

This chapter provides an overview of brief therapy in substance abuse treatment. First, the evidence for the efficacy of this approach is presented. The appropriateness of brief therapy is discussed next, and criteria are provided for determining duration of therapy. The components of all brief therapies are then discussed, including common characteristics

and steps in treatment. Finally, essential therapist knowledge and skills for conducting successful brief therapies are described.

The chapters following this present a cross-section of the approaches that are and have been used in brief therapy. No one approach is endorsed as the best or only approach for use with the range of persons with substance abuse disorders, nor are all of them considered by the Consensus Panel to be equally valid. Rather, the therapies in Chapters 4 through 9 were chosen because they either represent the most widely used brief therapies or they represent models that have good potential, are recommended by national experts, and will be of interest and assistance to providers who treat persons across the range of substance abuse disorders. Some of these approaches can be used with the whole range of people with substance abuse disorders; others are useful only for a smaller subset of that population. Each of the chapters that follows discusses a particular type of the individual therapies. However, each of the approaches described in Chapters 4 to 9 will provide useful techniques for the eclectic practitioner.

Research Findings

Research concerning the relative effectiveness of brief versus longer term therapies for a variety of presenting complaints is mixed. Some studies have found that planned, short-term therapies are as effective as lengthier (or unlimited) therapy (Koss and Shiang, 1993; Smyrnios and Kirkby, 1993). Other studies, such as the *Consumer Reports* mental health study (Seligman, 1995) and the National Institute of Mental Health (NIMH) Treatment of Depression Research Program (Blatt et al., 1995; Elkin, 1994), have found that longer term treatments generally lead to better outcomes as perceived by clients. Much depends on the modality being evaluated and the goals of the treatment. (More specific research evaluating different types of brief therapy is given in Chapters 4 to 9.)

There is, however, promising evidence that brief therapies as a treatment for substance abuse disorders are often as effective as lengthier treatments (Bien et al., 1993; Gottheil et al., 1998; McLellan et al., 1993; Miller and Hester, 1986a; Miller and Rollnick, 1991). These studies are positive but are primarily limited to program effectiveness studies with smaller sample sizes. Future research should both replicate previous work and use more rigorous designs that include experimental designs with randomization. Many of the fundamental questions about brief therapies—the optimum conditions under which they should be used, the economic cost-benefits, and level and type of provider, the most suitable types of clients—have yet to be studied.

The majority of clients in therapy (regardless of the modality) remain in treatment for between 6 and 22 sessions; 90 percent end treatment before completing 20 visits (Friedberg, 1999). The fact that many clients stay in therapy for relatively short periods of time suggests that brief therapy techniques should be much more common than they are in current clinical practice (Pekarik and Wierzbicki, 1986; Phillips, 1987). Many therapists trained in long-term treatment modalities choose not to use planned short-term therapies (Bloom, 1997). Alcohol and drug counselors often have to work with clients in a limited period of time, however, and could apply brief therapy techniques even when they are designed for treatment of different types of disorders and problems.

Because brief therapy is more effective than being on a waiting list, it could benefit many clients. Wolberg suggested that all clients seeking treatment be given brief therapy initially, before moving on to long-term treatments (Wolberg, 1980). Such an approach would help to reserve longer treatments for

clients with a greater need for them. However, there are clearly exceptions to this rule, such as clients who have a history of severe and persistent mental illness. Other criteria for assigning a client to longer term rather than brief therapy are presented in Figure 3-1.

Planned brief therapy can be adapted as part of a course of serial or intermittent therapy (Budman and Gurman, 1988; Cummings, 1990). When doing this, the therapist conceives a long-term treatment as a number of shorter treatments, which requires that the client's problems be addressed serially rather than concurrently. Because of insurance constraints, many therapists are now billing by episode and treating one problem at a time.

Brief therapy may prove to be a useful tool for reconceiving how therapy is delivered. For the treatment provider working with clients with substance abuse disorders, this means that a particular type of therapy could be applied to a specific problem associated with a client's substance abuse. By treating these allied problems, long-term goals, such as continued abstinence, may be more likely to be reached (Iguchi et al., 1997; McLellan et al., 1993).

When To Use Brief Therapy

Insufficient data are available to determine which populations would benefit most from brief therapy. Therefore, client needs and the suitability of brief therapy must be evaluated on a case-by-case basis. Some criteria for considering the appropriateness of brief therapy are presented in Figure 3-2. The American Society of Addiction Medicine (ASAM) client placement criteria for substance abuse treatment (ASAM, 1996) may also be useful for determining who could benefit from brief therapy (see discussion in Chapter 2).

Brief therapy may be appropriate for a moderate to heavy drinker such as a college student but inappropriate as the sole treatment for a commercial airline pilot who is alcohol dependent, no matter what the motivation is for treatment. Therapists must consider extenuating circumstances when recommending a particular course of treatment. In some programs, duration of therapy is determined mutually by the client and therapist; brief therapy may be the best option if the client objects to longer term treatment or if expense is an issue.

Research is needed to identify specific populations for which brief therapy would serve as the catalyst for resolution of substance abuse-related problems. The impact of brief therapy on chronically relapsing, substance-abusing persons has not been investigated. Because of these large gaps in research, therapists must rely on their clinical judgment to determine whether brief therapy is appropriate for a particular

Figure 3-1

Criteria for Longer Term Treatment

The following criteria can help identify clients who could benefit from longer term treatment:

- Failure of previous shorter treatment
- Multiple concurrent problems
- Severe substance abuse (i.e., dependence)
- Acute psychoses
- Acute intoxication
- Acute withdrawal
- Cognitive inability to focus
- Long-term history of relapse
- Many unsuccessful treatment episodes
- Low level of social support
- Serious consequences related to relapse

Figure 3-2

Selected Criteria for Providing Brief Therapy

- **Dual diagnosis issues such as a coexisting psychiatric disorder or developmental disability**
- The range and severity of presenting problems
- The duration of abuse
- Availability of familial and community supports
- The level and type of influence from peers, family, and community
- Previous treatment or attempts at recovery
- The level of client motivation (brief therapy may require more work on the part of the client but a less extensive time commitment)
- The clarity of the client's short- and long-term goals (brief therapy will require more clearly defined goals)
- The client's belief in the value of brief therapy ("buy in")
- Large numbers of clients needing treatment

The following criteria are derived from clinical experience:

- Less severe substance abuse, as measured by an instrument like the Addiction Severity Index (ASI)
- Level of past trauma affecting the client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment (e.g., 7-day average length of stay in county–jail-level correctional facilities; 30- to 45-day limitation in Job Corps program)
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment

client and what kind of modality would be most effective.

The best outcomes for brief therapy may depend on the therapist's skills, comprehensive assessments, and selective criteria for eligibility. Using selection criteria in prescribing brief therapy is critical, since many clients will not meet eligibility. The Consensus Panel hopes that brief therapy will be adequately investigated before managed care and third-party payors decide it is the only modality for which they will pay.

Brief therapy for substance abuse treatment is a valuable but limited approach, and it should *not* be considered a standard of care for all populations. In fact, time in treatment has been found to be directly related to better outcomes within a range of modalities, including therapeutic communities, psychotherapy, methadone maintenance therapy, and extended detoxification (Hubbard et al., 1997). Therefore, although brief therapy is a useful tool in a portfolio of interventions, its use should be targeted to those clients who are most likely to benefit.

Determining when to use a particular type of brief therapy is also an important consideration for counselors and therapists. Counselors recognize that not all clients are at the same stage in their readiness for treatment. Currently, the most widely used model for understanding clients' readiness for change is Prochaska and DiClemente's stages-of-change model, which is discussed in Chapter 2. (For more information about this model, see also TIP 35, *Enhancing Motivation for Change in Substance Abuse*

Treatment [CSAT, 1999c].) Counselors who use this model will have to determine which therapy is compatible with the client's stage of readiness for change and the tasks needed to move forward in the change process and develop an overall understanding of the course of change (DiClemente and Scott, 1997).

Clinical interventions should be targeted to the client's stage of readiness for change to increase his motivation to change behaviors and to augment a sense of empowerment in recovery. Therapies that work with experiential processes (such as consciousness raising, self-reevaluation, and a cognitive restructuring) are more important for understanding and predicting transition from preparation to action and from action to maintenance (Prochaska et al., 1994). Seeking and processing information, observing others, and gathering useful information in light of the client's situation are the primary activities reported most frequently during the contemplation stage (Prochaska et al., 1992). Especially during this early stage the client should be provided with information regarding addiction as well as confronted with the short- and long-term consequences of continued use. Asking the client to perform a risk appraisal of continued use as well as a benefit/risk-reduction appraisal of achieving abstinence can facilitate sound decisionmaking that involves a comparison of all potential gains and losses (Janis and Mann, 1977).

Finally, it will be essential to learn the client's perceived obstacles to engaging in treatment as well as to identify any dysfunctional beliefs that could sabotage the engagement process. The basic assumption behind this approach is that the way individuals evaluate a situation and cope with it determines their emotional reaction to it (Ellis and Grieger, 1977). The critical factor in determining an individual's response is the client's self-perception and associated emotions. The therapist should help the client recognize the messages she gives herself and help her correct problematic thinking patterns and dysfunctional beliefs (Kendall and Turk, 1984). Often, dysfunctional beliefs lead to low levels of perceived self-efficacy and subsequent inability to adopt or maintain the desired behavior (Bandura, 1986). It is important to note that self-efficacy shifts in a predictable way across the stages of behavior change, with clients progressively becoming more efficacious as they move through the stages (Marcus et al., 1992; Prochaska et al., 1994).

Approaches to Brief Therapy

Brief therapy uses a selected process to change a specific problem based on an underlying theory about the cause of the problem or the best way to encourage positive change. Figure 3-3 lists several therapeutic approaches that are applicable to brief therapy. These approaches can be used with clients with different types of problems and varying degrees of substance abuse severity.

Components of Effective Brief Therapy

Although different models of brief therapy may stress certain goals and activities more than others, all brief therapies have common characteristics (see Figure 3-4). In addition, brief therapies should incorporate several stages, including screening and assessment, an opening session that includes the establishment of treatment goals, subsequent sessions, maintenance strategies, ending treatment, and followup. These stages are discussed below.

Screening and Assessment

Screening and assessment are critical initial steps in brief therapy. Screening is a process in

Figure 3-3
Approaches to Brief Therapy

Approaches	Description
Cognitive therapy	This therapy posits that substance abuse disorders reflect habitual, automatic, negative thoughts and beliefs that must be identified and modified to change erroneous ways of thinking and associated behaviors. The desire to use substances is typically activated in specific, often predictable high-risk situations, such as upon seeing drug paraphernalia or experiencing boredom, depression, or anxiety. This approach helps clients examine their negative thoughts and replace them with more positive beliefs and actions. Many relapse prevention strategies use cognitive processes to identify triggering events or emotional states that reactivate substance use and replace these with more healthful responses. (See Chapter 4 for more information.)
Behavioral therapy	Using this approach, which is based on learning theories, the therapist teaches the client specific skills to improve identified deficiencies in social functioning, self-control, or other behaviors that contribute to substance use disorder. Some of the techniques that are used include assertiveness training, social skills training, contingency management, behavior contracting, community reinforcement and family training (CRAFT), behavioral self-control training, coping skills, and stress management. (See Chapter 4 for more general information on behavioral therapy and Chapter 8 for more information on CRAFT and other behavioral family therapies.)
Cognitive–behavioral therapy	This approach combines elements of cognitive and behavioral therapies, but in most substance abuse treatment settings it is considered a separate therapy. This approach focuses on learning and practicing a variety of coping skills. The emphasis is placed on developing coping strategies, especially early in the therapy. Cognitive–behavioral therapy is thought to work by changing what the client does and thinks rather than just focusing on changing how the client thinks. (See Chapter 4.)
Strategic/ interactional therapies	These approaches seek to understand a client's viewpoint on a problem, what meaning is attributed to events, and what ineffective interpersonal interactions and coping strategies are being applied. By shifting the focus to competencies, not weaknesses and pathology, the therapist helps clients change their perception of the problem and apply existing personal strengths to finding and applying a more effective solution. (See Chapter 5.)
Solution-focused therapy	Using this approach, the therapist helps a client with a substance abuse disorder recognize the exceptions to use as a means to reinforce and change behavior. Future behavior is based on finding solutions to problem behaviors. Little or no time is spent talking about the problem; rather, therapy is focused on solutions that have already worked for the client in the past. (See Chapter 5.)

Figure 3-3 (continued)
Approaches to Brief Therapy

Approaches	Description
Humanistic and existential therapies	These therapies assume that the underlying cause of substance abuse disorders is a lack of meaning in one's life, a fear of death, disconnectedness from people, spiritual emptiness, or other overwhelming anxieties. Through unconditional acceptance, clients are encouraged to improve their self-respect, self-motivation, and growth. The approach can be a catalyst for seeking alternatives to substances in order to fill the emptiness experienced and expressed as substance abuse. (See Chapter 6.)
Psychodynamic therapy	The psychodynamic therapist works with the assumption that a person's problems with substances are rooted in unconscious and unresolved past conflicts, especially in early family relationships. The goal is to help the client gain insight into underlying causes of manifest problems, understand what function substance abuse is serving, and strengthen present defenses to work through the problem. A strong therapeutic alliance with the therapist assists the client to make positive changes. (See Chapter 7.)
Interpersonal therapy	This therapy, which combines elements of cognitive and psychodynamic therapies, was originally developed to work with clients with depression but has been used successfully with substance-abusing clients. It focuses on reducing the client's dysfunctional symptoms and improving social functioning by concentrating on a client's maladaptive patterns of behavior. It is supportive in nature, providing encouragement, reassurance, reduction of guilt, and help in modifying the client's environment. (See Chapter 7 for more information.)
Family therapy	While not a distinct "school" of therapy, family therapy is a modality that either treats the client as part of a family system or considers the entire family as "the client." It examines the family system and its hierarchy to determine dysfunctional uses of power that lead to negative or inappropriate alignments or poor communication patterns and that contribute to substance use disorder by one or more family members. The therapist helps family members discover how their own system operates, improve communication and problem-solving skills, and increase the exchange of positive reinforcement. (See Chapter 8.)
Group therapy	This modality (also not a distinct theoretical school) uses many of the techniques and theories described to accomplish specified goals. In some group therapy, the group itself and the processes that emerge are central to helping clients see themselves in the reactions of others, although the content and focus of the groups vary widely. (See Chapter 9.)

Figure 3-1

Characteristics of All Brief Therapies

- They are either problem focused or solution focused; they target the symptom and not what is behind it.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the therapist.
- They rely on rapid establishment of a strong working relationship between client and therapist.
- The therapeutic style is highly active, empathic, and sometimes directive.
- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help the client have experiences that enhance self-efficacy and confidence that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

which clients are identified according to characteristics that indicate that they are possibly abusing substances. Screening does not inform the therapist of the severity of the individual client's substance abuse, only its presence and, in some cases, broad indications of risk. Screening identifies the need for more in-depth assessment and is not a substitute for an assessment.

Assessment is a thorough, extensive process that involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it. Screening and assessment procedures for brief therapy do not differ significantly from those used for lengthier treatments.

The assessment should determine whether the client's substance abuse problem is suitable for a brief therapy approach. The criteria for determining the appropriateness of brief therapy, presented in Figures 3-1 and 3-2, are first applied during the assessment stage.

It is reasonable to assume that brief therapies are most effective with clients whose problems are of short duration and who have strong ties to family, work, and community. However, limited client resources may also dictate the use of brief therapy. For example, if a client lacks the financial means to participate in a longer treatment process, a brief therapy approach is imperative. Some treatment is almost always better than no treatment. In addition, brief therapy may be indicated for clients who resist longer treatment, rather than risk the loss of an otherwise motivated client. (Technical Assistance Publication [TAP] 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* [CSAT, 1998a] contains further guidance on screening and assessment for brief therapy.)

Therapists should gather as much information as possible about a client before the first counseling session. One way to do this is to obtain copies of any notes taken by an intake worker or the referral source. However, when gathering information about a client from other sources, therapists should be sensitive to confidentiality and client consent issues (for more information see the section entitled "Confidentiality of Information About Clients" in Chapter 9 of the forthcoming TIP, *Substance Abuse Treatment for Persons With HIV/AIDS* [CSAT, in press]). Other options include asking intake workers to administer questionnaires, using computerized assessments, or asking the

client to complete an assessment form before the first session. The assessment instrument can be brief and informal, generating critical information in a short time. Although initial screening and assessment ideally should be conducted before the first therapy session, the process of assessment should continue throughout treatment.

A variety of brief assessment instruments, many of which are free, are available to clinicians. *Assessing Alcohol Problems* (National Institute on Alcohol Abuse and Alcoholism, 1995) is a useful source of research-validated instruments. Figure 3-5 provides a sample battery of brief assessment instruments that might be used in a brief therapy setting, ideally before the first counseling session. These instruments can provide the therapist with a quick assessment of the most critical domains about which clinical decisions should be made. In general, most clients can complete these instruments in less than 1 hour. These instruments should be supplemented in the first counseling session by a clinical assessment interview that covers the core areas outlined in the following section. For sample screening instruments and additional information on screening procedures see also TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians*; TIP 26, *Substance Abuse Among Older Adults*; TIP 31, *Screening and Assessing Adolescents for Substance Use Disorders*; and TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1997, 1998b, 1999a, 1999c).

For brief therapy, the setting in which treatment will occur frequently dictates the kind of assessment that can be conducted. Clients seek treatment in the type of agency they feel will best meet their needs (e.g., those who need to continue working while seeking treatment will likely enter an outpatient program). Constraints may be placed by insurance companies or other outside forces. For example, managed care environments generate their own assessment criteria. Assessment often must be conducted outside the treatment facility and may not qualify as a reimbursable visit. In addition, private practitioners often do not have easy access to background information

Figure 3-5
Sample Battery of Brief Assessment Instruments

Assessment Domain	Example Instrument(s)
Quantity/frequency of use	Timeline Follow Back Technique
Severity of dependence	Short Alcohol Dependence Data (SADD), Severity of Dependence Scales (SDS), CAGE
Consequences of use	Michigan Alcoholism Screening Test (MAST), Drug Abuse Screening Test (DAST), Substance Abuse Subtle Screening Inventory (SASSI), DRINK
Readiness to change	Commitment to Change Algorithm, SOCRATES
Problem areas	Problem Checklist from Comprehensive Drinker Profile, Problem Oriented Screening Instrument for Teenagers (POSIT), Adolescent Assessment/Referral System (AARS)
Treatment placement	Addiction Severity Index (ASI)
Goal choice and commitment	Intentions Questionnaire

Sources: Allen and Columbus, 1995; Miller, 1991.

regarding a potential client. In a primary care office, screening and assessment consist only of taking a client's history and conducting a physical examination.

Core assessment areas

Before proceeding with brief therapy for substance abuse disorders, a number of areas should be assessed, including the following:

- Current use patterns
- History of substance abuse
- Consequences of substance abuse (especially external pressures that are bringing the client into treatment at this time, such as family or legal pressures)
- Coexisting psychiatric disorders
- Information about major medical problems and health status
- Information about education and employment
- Support mechanisms
- Client strengths and situational advantages
- Previous treatment
- Family history of substance abuse disorders and psychological disorders

As mentioned earlier, assessment is critical not only before beginning brief therapy but also as an ongoing part of the process. Only by continually assessing the client's progress and problems can the therapist accomplish the goals of brief therapy in the limited timeframe. In addition, ongoing assessment can function as a therapeutic tool because it helps clients identify when they are at risk of using substances as well as other negative behaviors.

The Opening Session

In the first session, the main goals for the therapist are to gain a broad understanding of the client's presenting problems, begin to establish rapport and an effective working relationship, and implement an initial intervention, however small. The therapist must accomplish certain critical tasks during the first session, including

- Producing rapid engagement
- Identifying, focusing, and prioritizing problems
- Working with the client to develop possible solutions to substance abuse problems and a treatment plan that requires the client's active participation
- Negotiating the route toward change with the client (which may involve a contract between client and therapist)
- Eliciting client concerns about problems and solutions
- Understanding client expectations
- Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
- Making referrals for critical needs that have been identified but can not be met within the treatment setting

Goals of treatment

Therapists should identify and discuss the goals of brief therapy with the client early in treatment, preferably in the first session. The client has a critical role in determining the goals of therapy, and the therapist might have to be flexible. The therapist can recommend treatment goals, but ultimately they are established through interaction and negotiation with the client. If a client has certain expectations of therapy that make it difficult for her to commit to the goals and procedures of brief therapy or to a particular therapeutic approach, other approaches should be considered or a referral made.

Treatment goals should focus on the central problem of substance abuse and may include the following:

- Making a measurable change in specific target behaviors associated with substance abuse
- Helping the client demonstrate a new understanding and knowledge of problems and issues related to substance abuse
- Improving the client's personal relationships
- Resolving other identified problems (e.g., work problems, support group attendance)

The goals of brief therapy may be more client driven than those developed in long-term therapies because, by design, the therapist does not have as long to shape these goals. A variety of goals besides those related to substance abuse disorders can be addressed effectively in a brief therapy modality, but given time constraints, therapists will have to limit the number of issues addressed. The key is to identify the goals most important to the client and to work with him to achieve those goals, keeping in mind the ultimate goal of sobriety or decreased use.

Although abstinence is an optimal clinical goal, it still must be negotiated with the client (at least in outpatient treatment settings). Abstinence as a goal is not necessarily the sole admission requirement for treatment, and the therapist may have to accept an alternative goal, such as decreased use, in order to engage the client effectively.

Subsequent Sessions

In subsequent sessions of brief therapy, therapists should

- Work with the client to help maintain motivation and address identified problems, monitoring whether any accomplishments are consistent with the treatment plan and the client's expectations
- Reinforce—through an ongoing review of the treatment plan and the client's expectations—the need to do the work of brief therapy (e.g., maintain problem focus, stay on track)
- Remain prepared to rapidly identify and troubleshoot problems
- Maintain an emphasis on the skills, strengths, and resources currently available to the client
- Maintain a focus on what can be done immediately to address the client's problem
- Consider, as part of an ongoing assessment of progress, whether the client needs further therapy or other services and how these services might best be provided
- Review with the client any reasons for dropping out of treatment (e.g., medical problems, incarceration, the emergence of severe psychopathology, treatment noncompliance)

Maintenance Strategies

Maintenance strategies must be built into the treatment design from the beginning. A practitioner of brief therapy must continue to provide support, feedback, and assistance in setting realistic goals. Also, the therapist should help the client identify relapse triggers and situations that could endanger continued sobriety.

Strategies to help maintain the progress made during brief therapy include the following:

- Educating the client about the chronic, relapsing nature of substance abuse disorders
- Developing a list of circumstances that might provide reasons for the client to return to treatment and plans to address them
- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future (or identifying specific problems that might have emerged but were not dealt with in treatment)
- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors

- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency (encouraging the client to work through his own problems and stay focused on the goals that have been set in therapy) and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups, family support, and community support (e.g., religious or social service organizations), which can be done much earlier than in long-term therapy

In addition to routine progress assessments that are conducted throughout the therapy, midway through the agreed-upon number of sessions the therapist should formally review the client's progress. Particularly because of the time limitations of brief therapy, continuing assessments are essential to ensure that problems are addressed and that the client can recognize when she is most at risk of slipping into substance abuse or other negative behaviors. Assessments will also take into account the level of the client's progress. When the client has made agreed-upon behavior changes and has resolved some problems, the therapist should prepare to end the brief therapy. If a client progresses more quickly than anticipated, it is not necessary to complete the full number of sessions.

Ending Treatment

Termination of therapy should always be planned in advance. In many types of brief therapy, the end of therapy will be an explicit focus of discussion in which the therapist should

- Leave the client on good terms, with an enhanced sense of hope for continued change and maintenance of changes already accomplished
- Leave the door open for possible future sessions dealing with the client's other problems
- Elicit commitment from the client to try to follow through on what has been learned or achieved
- Review what positive outcomes the client can expect
- Review possible pitfalls the client may encounter (e.g., social situations, old friends, relationship issues) and talk about the likelihood of a good outcome and indicators of a poor outcome
- Review the early indicators of relapse (e.g., depression, stress, anger)

In brief therapy, issues regarding referral and followup are often different from those of longer term therapy because clients will not necessarily remain in contact with the therapist. If the goals of therapy have not been met, more intensive therapy may be suggested.

During continual assessment of the progress of the therapy, the therapist may decide that referral is appropriate before treatment ends. It is important to remember that referrals can be made at any time during treatment, not just at the end of the treatment process. Reasons for initiating referrals during or at the end of treatment include the following:

- The client needs ancillary services for other problems that have been recognized during therapy (e.g., medical or psychiatric problems).
- The client requires more intensive therapy.
- The client may benefit from involvement with a support group, such as Alcoholics Anonymous, Self-Management and Recovery Training (SMART), or Moderation Management (which may also be a part of the brief therapy process).

Followup

It is always advisable for the therapist to follow up with clients who have completed brief therapy. Followup reassures the client that the therapist is concerned about her progress. In addition, it is an effective way to gather much-needed data regarding treatment effectiveness. The therapist might obtain such data by conducting a client satisfaction survey via telephone or mail. Aftercare, when additional treatment is provided, is not part of the brief therapy process. However, followup activities such as offering reassurance and tracking client status are customary.

Therapist Characteristics

To successfully integrate different short-term therapies into practice, therapists benefit from a firm grounding in theory and a broad technical knowledge of the many different approaches available. When appropriate, elements of different brief therapies may be combined to provide successful outcomes. However, it is important to remember that the effectiveness of highly defined interventions (e.g., workbook-driven interventions) used in some behavioral therapies depends on administration of the entire regimen. The therapist must use caution in combining and mingling certain techniques and must be sensitive to the cultural context within which therapies are integrated. Therapists should also be sufficiently trained in the therapies they are using and should not rely solely on a manual such as this to learn those therapies. Appendix B provides some resources for further education.

Although therapists with many levels of training and experience can conduct brief interventions, certain skills and training are particularly important for conducting effective brief therapy. Those who specialize in providing brief therapy are likely to be more successful when grounded in a specific model of psychotherapy but possess a general understanding of other models from which appropriate techniques may be drawn. They should be adept at determining early in the assessment process the client needs or goals that are appropriate to address. Related to this, and equally important, therapists must establish relationships that facilitate referral when the client's needs or goals cannot be met through brief therapy. A comprehensive description of the professional and personal attributes that practitioners need to be effective providers of substance abuse treatment is provided in TAP 21, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 1998a). TAP 21 emphasizes that practitioners should

- Be empathic
- Be able to integrate their training—whether in substance abuse treatment or other disciplines such as social work, medicine, nursing, or psychology—with experience, both professional and personal, to create the best therapeutic environment for the client
- Have a mature sense of personal and professional boundaries
- Be sensitive to the cultural and spiritual needs of the client
- Follow appropriate Federal, State, and agency regulations in the provision of substance abuse treatment services

Providers of brief therapy must focus effectively on identifying and adhering to specific therapeutic goals in treatment. They should be able to extract techniques from longer term therapies and adapt them within the parameters of brief therapy. The provider of brief therapy will have to focus on short-term change that can have long-term benefits and avoid issues that are more global. The therapist must be able to shift approaches depending on what is learned about the client during treatment.

Brief therapy is amenable to the use of a wide range of techniques from which the therapist can choose. It is therefore helpful for therapists to be aware of the broad range of therapeutic techniques available. Exposure to several psychotherapeutic approaches (many described in the following chapters) allows therapists to understand how other clinicians might approach the situation, what a client might have experienced in previous treatments, and how to build on these experiences.

Brief therapy for substance abuse disorders is often helpful, but should not be considered a standard of care for all persons or populations. Brief therapy, as presented in this TIP, can be a contained modality of treatment and not an episodic form of long-term therapy. In fact, successful brief therapy may be the only treatment some clients will require.

4 Brief Cognitive–Behavioral Therapy

An approach that has gained widespread application in the treatment of substance abuse is cognitive–behavioral therapy (CBT). Its origins are in behavioral theory, focusing on both classical conditioning and operant learning; cognitive social learning theory, from which are taken ideas concerning observational learning, the influence of modeling, and the role of cognitive expectancies in determining behavior; and cognitive theory and therapy, which focus on the thoughts, cognitive schema, beliefs, attitudes, and attributions that influence one's feelings and mediate the relationship between antecedents and behavior. Although there are a number of similarities across these three seminal perspectives (see Carroll, 1998), each has contributed unique ideas consistent with its theoretical underpinnings. However, in most substance abuse treatment settings, the prominent features of these three theoretical approaches are merged into a cognitive–behavioral model.

Before focusing more specifically on the cognitive–behavioral model, this chapter examines the behavioral and cognitive theories and therapies that serve as the foundations of and have contributed significantly to the cognitive–behavioral approach to substance abuse treatment. Both behavioral and cognitive theories have led to interventions that individually have been proven effective in treating substance abuse. Several of these are reviewed, as they have been successfully incorporated into an integrated cognitive–behavioral model of addictive behaviors and their treatment.

Behavioral Theory

In contrast to many other methods, behavioral approaches to the treatment of substance abuse have substantial research evidence in support of their effectiveness. Two recent comprehensive reviews of the treatment research literature offer strong evidence for their effectiveness (Holder et al., 1991; Miller et al., 1995). However, some critics argue that this is because behavioral approaches have been developed under controlled conditions and that in "real" therapy there are many more variables at work than can be measured in controlled experiments. Providers should take advantage of the wide range of behavioral therapy techniques that are available. These techniques can be conducted successfully in individual, group, and family settings, among others, to help clients change their substance abuse behaviors.

Behavioral approaches assume that substance abuse disorders are developed and maintained through the general principles of learning and reinforcement. The early behavioral models of substance abuse were influenced primarily by the principles of both Pavlovian classical conditioning and Skinnerian operant learning (O'Brien and Childress, 1992; Stasiewicz and Maisto, 1993). (See Figure 4-1 for definitions of classical conditioning and operant learning.)

Today, behavioral therapy for the treatment of substance abuse disorders is based primarily, though not exclusively, on methods derived from both operant and classical theories of learning. A major tenet of behavioral therapy is that because substance abuse is a learned behavior pattern, changing the reinforcement contingencies that govern this behavior can modify it. This goal can be achieved by focusing on either the classically conditioned craving responses or on the operant reinforcement patterns that are assessed as maintaining the substance abuse. More specifically, the classically conditioned response can be addressed either through extinction or counterconditioning procedures; the operant responses can be targeted through contingency

Figure 4-1

Classical Conditioning and Operant Learning

According to the theory of *classical conditioning*, an originally neutral stimulus comes to elicit a response as a result of being paired with an unconditioned stimulus (an event that elicits a response without any prior learning history) or with a conditioned stimulus. As applied to substance abuse, repeated pairings between the emotional, environmental, and subjective cues associated with the use of substances and the actual physiological and phenomenological effects produced by specific substances lead to the development of a classically conditioned response. Subsequently, when the substance abuser is in the presence of such cues, a classically conditioned withdrawal state or craving is elicited. Cocaine- and opiate-dependent individuals, for example, experience marked physiological arousal and report strong craving when they see their drug works and other drug paraphernalia or when they experience negative emotions such as depression—even after prolonged drug-free periods (Childress et al., 1994, 1988; Ehrman et al., 1992). Alcohol-dependent clients experience similar physiological reactivity to alcohol-related cues such as being in a bar or watching others drink (Rohsenow et al., 1991). These cues can become "triggers" or high-risk situations that can lead to substance use and relapse.

Operant learning refers to those behaviors that are increased in frequency by reinforcement. Behaviors that result either in rewarding or positive outcomes or that allow the individual either to avoid or escape from negative consequences are likely to increase in frequency. Substance abuse in the presence of classically conditioned cues is instrumental in reducing or eliminating the arousal associated with a state of craving, thus serving to reinforce the substance abuse behavior. That is, the behavior serves a basic rewarding function for the individual. This represents the second form of learning, operant conditioning. An alcohol-dependent person who drinks to feel more social and less anxious or a cocaine abuser who gets high to overcome depression is using substances in an instrumental way. To the extent that they experience the effects they seek, the greater the likelihood they will use substances under similar circumstances in the future. Presumably, people continue to abuse substances even in the face of negative consequences (e.g., legal, marital, or health problems) because these consequences are quite removed in time from the point of use; also, the more immediate positively reinforcing effects of the substance typically override consideration of such consequences.

management or coping skills training. (More information about the basic assumptions of behavioral theories concerning substance abuse disorders is contained in Figure 4-2.)

According to behavioral theory, changes in behavior come about through learning new behaviors. Because substance abuse behavior is learned, it can be changed by teaching the client more adaptive, alternative behaviors aimed at achieving the same rewards. Figure 4-3 provides an overview of some of the advantages of behavioral theories of substance abuse and dependence and their treatment.

By its very design, most behavioral therapy is brief. The aim is not to remake personality, but rather to help the client address specific, identifiable problems in such a way that the client is able to apply the basic techniques and skills learned in therapy to the real world, without the assistance of the therapist. Behavioral therapy focuses more on identifying and changing observable, measurable behaviors than other therapeutic approaches and hence lends itself to brief work. Treatment is linked to altering the behavior, and success is the change, elimination, or enhancement of particular behaviors.

Regular assessment and measurement of progress are integral to effective behavioral therapy. Decisions about the length of treatment are made on the basis of these assessments, rather than according to a formula or theoretical assumption about how long therapy should take. Each individual is approached as a unique case, albeit one to which broad principles can be applied.

Behavioral Therapy Techniques Based on Classical Conditioning Models

Extinction and Cue Exposure Procedures

A principal of classical conditioning is that if a behavior occurs repeatedly across time but is not reinforced, the strength of both the cue for the behavior and the behavior itself will diminish and the behavior will extinguish. This principal has been the foundation of behavioral treatments known as "cue exposure" (O'Brien et al., 1990; Rohsenow et al., 1991; Rohsenow and Monti, 1995). Even after relatively long periods of abstinence from substances, being placed in situations that have physical–environmental, social, or emotional cues associated with past

Figure 4-2
Basic Assumptions of Behavioral Theories of Substance Abuse and Its Treatment

- **Human behavior is largely learned, rather than determined by genetic factors.**
- The same learning processes that create problem behaviors can be used to change them.
- Behavior is largely determined by contextual and environmental factors.
- Covert behavior such as thoughts and feelings is subject to change through the application of learning principals.
- Actually engaging in new behavior in the contexts in which they are to be performed is a critical part of behavior change.
- Each client is unique and must be assessed as an individual in a particular context.
- The cornerstone of adequate treatment is a thorough behavioral assessment.

Source: Rotgers, 1996.

Figure 4-3
Advantages of Behavioral Theories in Treating Substance Abuse Disorders

- **Flexible in meeting specific client needs**
- Readily accepted by clients due to high level of client involvement in treatment planning and goal selection
- Soundly grounded in established psychological theory
- Derived from scientific knowledge and applied to treatment practice
- Structured in its guidelines for assessing treatment progress
- Empowering clients to make their own behavior change
- Effective, according to strong empirical and scientific evidence

Source: Rotgers, 1996.

substance abuse will elicit strong physiological arousal reactions and reports of strong sensations of craving. In cue exposure, a client is purposefully presented with such cues physically (e.g., by showing his personal drug paraphernalia or by accompanying him into a well-frequented bar), or visually through video depiction of a drug-using scenario or through visualization of such a scenario. However, the client is prevented from drinking or taking drugs. This extinction process, over time, leads to a decreased reactivity to such cues.

O'Brien and colleagues found that cocaine-dependent clients showed the prototypical arousal and craving responses when first presented drug-related cues that reminded them of their drug use (O'Brien et al., 1990). Clients then began the cue-extinction protocol. By the sixth 1-hour treatment session, they no longer reported either subjective highs or physiological withdrawal. By the 15th session, all clients reported that they no longer experienced craving when presented with the drug-related cues. Clients who received the cue exposure as part of their standard outpatient treatment for cocaine use were also less likely to drop out of treatment and had more cocaine-free weeks than did clients attending the same outpatient program but who did not receive cue exposure.

Counterconditioning and Aversion Procedures

Another method used to modify behavior according to classical conditioning principles is to make behaviors that had been associated with positive outcomes less appealing by more closely associating them with negative consequences. By repeatedly pairing those cues that previously elicited a particular behavior with negative rather than positive outcomes, the cues lose their ability to elicit the original classically conditioned response; instead, they elicit a negative outcome. This has led to the development of what have been described as *aversive conditioning* or *counterconditioning* treatment approaches (Howard et al., 1991; Rimmele et al., 1995). These procedures repeatedly pair negative outcomes with the substance-related cues previously associated with the positive consequences of substance use.

For example, the Shick-Shadel Hospital in Seattle uses aversive conditioning techniques with alcohol-dependent clients (Lemere, 1987). Before a treatment session, the client is asked to drink a warm saline solution and is given an emetic medication that will ultimately lead the client to become nauseated and to vomit. The client is then brought into "Duffy's Bar," a room filled with vivid alcohol- and drinking-related

posters, a bar with bottles of a large number and wide range of alcoholic beverages, and other drinking-related cues. The room is meant to highlight and make more salient the cues associated with drinking. The client is asked to identify her favorite type and brand of alcohol. After pouring a drink, she is asked to swirl the alcohol around in the glass, to smell the alcohol, to place the glass to her lips and taste, and then to begin to take a sip of the drink. At that point, as she is about to take a drink, the effects of the emetic drug "kick in" and the client becomes nauseated and vomits. Over repeated sessions, which occur every other day for a 10-day period, the alcohol-related sight, smell, and taste cues not only do not elicit craving and positive feelings about drinking, but rather they now elicit conditioned nausea.

Therapies based on counterconditioning theory typically use chemically induced aversion or electric shock as negative consequences to be paired with the substance-related cues. Visual imagery can also be used in a technique called *covert sensitization*. In this procedure, the client is asked to imagine as vividly as possible a sequence of events that begin by seeing his favorite bar; this is typically accompanied by increased craving. As the person proceeds further in imagining entering the bar, sitting down, ordering a drink, and so on, the initial sense of craving shifts to mild discomfort. As he visualizes beginning to take a drink and tastes the alcohol, he is then asked to imagine becoming violently sick and vomiting (Rimmele et al., 1995).

While aversive conditioning procedures have most often been used in the treatment of alcohol dependence, they have also been applied to the treatment of marijuana and cocaine use (Frawley and Smith, 1990; Smith et al., 1988). It should be noted that these aversive conditioning techniques, as well as cue exposure approaches, are best viewed as components of a more comprehensive treatment program rather than as independent, free-standing treatments (O'Brien, et al., 1990; Smith and Frawley, 1993). In this context, Smith and colleagues reported positive outcomes for dependent users of both alcohol and cocaine who received chemical aversion procedures as part of their treatment in comparison to those who did not receive similar treatment (Frawley and Smith, 1990; Smith et al., 1997). Rimmele and colleagues also recommended covert sensitization as a highly effective and portable treatment component which, unlike chemical or electric aversion therapies, can be used at any time and in any setting as a self-control strategy (Rimmele et al., 1995).

Behavioral Therapy Techniques Based on Operant Learning Models

A number of substance abuse treatment strategies have derived from operant learning principles. While they are often incorporated into broad-spectrum cognitive–behavioral approaches, they have also been used as independent forms of treatment. Common elements of behavioral treatments based on theories of operant learning include contingency management, behavior contracting, community reinforcement, and behavioral self-control training. The following sections describe some of the elements used in brief behavioral therapies based on the operant learning model.

Contingency Management and Behavior Contracting

In contingency management approaches, an active attempt is made to change those environmental contingencies that can influence substance abuse behavior (Higgins et al., 1998). The goal is to decrease or stop substance use and to increase behaviors that are incompatible with use. In particular, those contingencies that are found through a functional analysis (see Figure

4-4) to prompt as well as reinforce substance abuse are weakened by associating evidence of substance use (e.g., a drug-positive urine screen) with some form of negative consequence or punishment. Contingencies that prompt and reinforce behaviors that are incompatible with substance abuse and that promote abstinence are strengthened by associating them with positive reinforcers.

One recent study evaluated the effects of a voucher program in the treatment of methadone-maintained opiate addicts with a history of cocaine use (Silverman et al., 1998). Clients who provided cocaine-free urine samples received vouchers that had monetary value. The value of the vouchers increased as the number of consecutive cocaine-free urine samples increased. Clients in the contingent voucher condition, compared to those who received vouchers on a noncontingent basis, reported decreased craving for cocaine and significantly increased cocaine abstinence. A more general positive treatment effect was also noted, with clients in the contingent voucher condition also demonstrating an increased abstinence from opiates.

Chutuape and colleagues have also shown that providing methadone take-home privileges contingent on drug-free urine samples among methadone clients with persistent multiple drug abuse resulted in marked reductions in drug use (Chutuape et al., 1999). Nearly 25 percent of clients in the take-home incentive program met the criterion for marked reduction in drug use and also were significantly more likely to achieve the criterion of having 4 consecutive weeks of drug-free urine samples. None of the clients in a control condition (no take-home privileges) met these criteria. Whereas only 2 percent of the control group evidenced a decrease in the frequency of drug-positive urines, clients in the incentive program decreased use between 14 and 18 percent.

In addition to increasing drug abstinence, similar voucher systems have been effective in maintaining attendance of methadone clients at a job-skills training program (Silverman et al., 1996). However, in contrast to drug treatment, less evidence is available concerning the effectiveness of such contingency management approaches in the treatment of alcohol problems (Higgins et al., 1998).

Attempts to incorporate real-world contingencies into treatment programs are increasing (Higgins, 1999). Clearly, programs can build contingencies such as take-home medication privileges into the structure of their programs. Milby and colleagues provide an example of a contingency management system incorporated into treatment that is more relevant to real-life situations of users (Milby et al., 1996). In this study, homeless substance abusers were enrolled in an intensive day treatment program. A subgroup of these clients was also involved in a contingent work therapy and housing program. As long as the clients

Figure 4-4
Functional Analysis

A functional analysis probes the situations surrounding the client's substance abuse. Specifically, it examines the relationships among stimuli that trigger use and the consequences that follow. This type of analysis provides important clues regarding the meaning of the behavior to the client, as well as possible motivators and barriers to change. In behavioral therapy, this is the first step in providing the client with tools to manage or avoid situations that trigger substance use. Functional analysis yields a roadmap of a client's interpersonal, intrapersonal, and environmental catalysts and reactions to substance use, thereby identifying likely precursors to substance use. (For more information on this topic, see the section below under the heading "Cognitive–Behavioral Therapy.")

remained substance free, they were able to remain in the work program and remain in the therapeutic housing; if they were found to be drinking or using drugs, they became ineligible for both the job training/work program and housing. Clients involved in the abstinence-contingent program had fewer cocaine-positive urine samples, fewer days of drinking, fewer days of homelessness, and more days of employment during the followup period than those in the standard treatment.

Naturalistic contingencies may also be useful in treatment. These contingencies include threatened loss of job, spouse, or driver's license and were positively related to treatment outcome among alcohol users (Krampen, 1989). However, the prognosis was less favorable in those patients who had already experienced a loss in one of those areas because the contingency no longer existed for them.

Higgins and colleagues noted that written contracts may be used to help implement a contingency management program (Higgins et al., 1998). The contract should specify clearly, using the client's own words, the target behavior to be changed, the contingencies surrounding either changing behavior or not, and the timeframe in which the desired behavior change is to occur. The act of composing and signing a contract is a small but potentially important ritual signifying the client's commitment to the proposed change. In the contract, the client may include contingencies, especially rewards or positive incentives that will reinforce target behaviors (e.g., attending treatment sessions, getting to 12-Step meetings, avoiding stimuli associated with substance use). Goals should be clearly defined, broken into small steps that occur frequently, and revised as treatment progresses; contingencies should occur quickly after success or failure.

Most often, behavioral contracts and contingency management procedures are embedded in a more comprehensive treatment program. Contracts targeting goals supportive of recovery (e.g., improving vocational behavior, saving money, being prompt for counseling, regularly taking medication) are generally more likely to be achieved and lead to better outcomes than those more directly related to substance use (e.g., clean urine samples) (Anker and Crowley, 1982; Iguchi et al., 1997; Magura et al., 1987, 1988). For instance, research found that receiving vouchers contingent on completing objective, individually tailored goals related to one's overall treatment plan was more effective in reducing substance abuse than either a voucher system specifically targeting drug-free urine samples or a standard treatment without either of these contingency contracts added (Iguchi et al., 1997). The effectiveness of such contracts also appears to be linked to the severity of the consequences that might result from a broken contract (Magura et al., 1987).

Behavioral contracting and contingency management are often found as elements in a number of more comprehensive approaches such as community reinforcement and behavioral self-control training.

Community Reinforcement Approach

The community reinforcement approach (CRA) was developed as a treatment for alcohol abuse disorders (Azrin, 1976; Hunt and Azrin, 1973). After a period during which it appears to have been little used, it has received increased interest as a behavioral approach to substance abuse (Higgins et al., 1998; Meyers and Smith, 1995; Smith and Meyers, 1995). CRA is a broad-spectrum approach based on the principles of operant learning, the goal of which is to increase the likelihood of continued abstinence from alcohol or drugs by reorganizing the client's environment. In particular, CRA attempts to weaken the influence of reinforcement received by substance abuse and its related activities by increasing the availability and frequency of

reinforcement derived from alternative activities, particularly those vocational, family, social, and recreational activities that are incompatible with substance abuse (Higgins et al., 1998).

A goal of CRA is to make these alternative interpersonal and social sources of reinforcement available when the person is sober or drug-free, but to make them unavailable if the person drinks or uses. The program consists of a number of components, and it can be tailored to the specific circumstances of a client. Vocational counseling and job clubs can improve clients' basic skills as well as job-seeking skills (e.g., résumé development, application completion, job interview skills). Social and recreational counseling is provided to help clients learn about and sample a number of substance-free recreational pursuits and social activities. In some cases, social clubs have been established to provide clients with a substance-free environment where they can gather and have fun.

For those clients who are married or in a relationship, marital counseling and communication skills training are provided to enhance the quality of the relationship and reduce the stress of substance-related arguments. Couples are trained to give each other positive attention through compliments, appreciation, affection, and offers to help. A focus is placed on clarifying expectations that each partner has about the behavior of the other. For those with a problem with alcohol, medication (e.g., disulfiram [Antabuse]) monitored by the spouse may be used. The client also receives training in problemsolving and in ways to refuse requests to drink or use drugs.

CRA has been described as a promising but underutilized treatment for alcohol abuse (McCrady, 1991). A review of the alcohol treatment outcome literature identifies CRA among those interventions having the greatest empirical support (Miller et al., 1995). CRA's application to substances other than alcohol also appears to have been successful (Higgins et al., 1998). This extension is exemplified by the recent publication of a detailed CRA therapy manual for the treatment of cocaine dependence by the National Institute on Drug Abuse (Budney and Higgins, 1998). This manual relies heavily on the early work of Higgins and colleagues in evaluating the effectiveness of combining CRA with contingency management approaches (e.g., use of vouchers for drug-free urine samples) in the treatment of cocaine dependence (Higgins et al., 1991, 1993). In comparison to standard outpatient treatment, clients in the CRA-plus-vouchers condition remained in treatment longer, had more continuous weeks of drug-free urine samples, and had greater amounts of cocaine abstinence even at a 12-month followup. A similar pattern of findings has been obtained with methadone-maintained opiate addicts (Abbott et al., 1998).

The CRA model has been modified into the Community Reinforcement and Family Training procedure (CRAFT) (Meyers et al., 1996). The client's significant others and family members, who are an integral part of this approach, receive training in behavior modification and enhancing motivation. CRAFT seeks to reduce or stop substance abuse by working through nonusing family and friends. While CRA involves family or significant others in treatment, CRAFT is more of a form of family therapy (rather than individual therapy) and therefore is discussed in Chapter 8 of this TIP.

Behavioral Self-Control Training

In contrast to CRA, which incorporates a wide array of individuals in the treatment process, the behavioral self-control training approach focuses on the substance abuser and his attempts to reduce or stop substance abuse either on his own or with the aid of a therapist

(Hester, 1995; Hester and Miller, 1989). The goal of this approach is either moderation and harm reduction or abstinence. As applied to alcohol problems, the approach consists of the eight sequential steps listed below (Hester, 1995):

1. The client establishes an upper limit on the number of drinks per day and the peak blood alcohol level on any one drinking occasion.
2. The client begins to self-monitor both the number of drinks taken and the drinking setting (e.g., when, where, with whom, how he is feeling). This provides the basis of a functional analysis.
3. The client begins to modify the rate at which alcohol is consumed. This might be done by switching from the individual's standard alcoholic beverage to one containing less alcohol, by sipping a drink over a longer period of time, or by spacing the number of drinks consumed across time.
4. The client must develop and practice being able to refuse drinks assertively when offered them.
5. The client establishes a reinforcement system to reward the achievement of these drinking-related goals.
6. Through the process of self-monitoring, the client is able to determine those social, emotional, and environmental antecedents that prompt overdrinking.
7. The client learns new coping skills to use rather than relying on drinking as a means of coping.
8. The client attempts to learn ways to avoid relapsing back to heavy drinking.

Although a therapist may guide the individual in a behavioral self-control model, the substance abuser maintains primary responsibility for changing his behavior. During the course of therapy, the client and therapist meet in brief sessions to go over homework and ensure that the client is following through. Rather than involvement with a therapist, the person may be guided instead by self-help manuals (Miller and Munoz, 1982; Sanchez-Craig, 1995), intervention via correspondence (Sitharthan et al., 1996), or even a computer program (Hester and Delaney, 1997).

McCrady also included behavioral self-control training as another promising but underutilized treatment approach (McCrady, 1991). Hester indicated that there is good empirical support for behavioral self-control training in achieving the goal of moderate, nonproblematic drinking (Hester, 1995). In randomized clinical trials, problem drinkers assigned to behavioral self-control with a goal of either moderation or abstinence typically have comparable long-term outcomes. Although behavioral self-control approaches have been used primarily with alcohol problems, they have also been used with other substances such as opiates (van Bilsen and Whitehead, 1994).

Application of Behavioral Techniques

Behavioral therapies are often delivered using a specific manual, but they are also adaptable to the individual client. A number of the behavioral techniques described here are also used by therapists using cognitive–behavioral therapy. The following sections describe how brief behavioral therapy might be applied at different stages of treatment. Some of the techniques developed for brief behavioral therapy are also presented.

Initial session

The initial session in brief behavioral therapy involves an exploration of the reasons the client is seeking treatment at this particular time; the extent to which this motivation for treatment is intrinsic, rather than influenced by external sources; the areas of concern that the client and significant others may have about his substance abuse; the situations in which she drinks or uses

excessively; and the consequences she experiences (both positive and negative, as well as proximal and removed from the actual substance abuse). This involves an abbreviated functional analysis. (See the section with that name later in this chapter.)

The information gained in the session will assist the counselor in determining the antecedents that prompt substance abuse and the reinforcers that appear to maintain it. Based on the information obtained, the counselor can begin to formulate a treatment plan with respect to the specific target behaviors to address, the behavioral interventions that address these target behaviors most effectively, and behaviors incompatible with heavy drinking that should be reinforced and targeted for an increase in frequency.

During the initial session, the therapist should note the most salient problems identified by the client and intervene with them first. The therapist also should assess the client's readiness to change and then develop initial behavioral goals in collaboration with the client. For substance abuse disorders, these goals will, of course, involve a reduction in or cessation of substance use. In addition to targeting substance abuse as the primary focus, other goals will be developed to assist the client in improving daily functioning (e.g., by reducing stress, as described in Figure 4-5). The focus of the therapy might be to negotiate with the client to accomplish these other goals by reducing use. The therapist will continue to engage the client in a collaborative process in which they determine those problems to target, their relative priority, and ways to resolve them.

Near the end of the initial session the therapist reviews with the client the procedure for filling out the self-monitoring records. In addition, the therapist might provide the client with self-help manuals that outline the specific steps in the behavioral self-control process. Self-monitoring of substance abuse behavior is one form of written homework common in behavioral approaches; other types of homework might also be used. Homework assignments can include such things as keeping a journal of behaviors, activities, and feelings when using substances or at risk of doing so. In the brief behavioral model designed by Phillips and Weiner, techniques such as programmed therapy and writing therapy (see Figure 4-6) make what is typically thought of as "homework" the central concern of the therapy session (Phillips and Weiner, 1966).

Later sessions

Based on a review of the information collected through self-monitoring, subsequent sessions involve negotiation about treatment goals. While many problem drinkers, for example, choose a moderation goal, across time those with more severe problems shift to a goal of abstinence (Hodgins et al., 1997). Later sessions might also consider the introduction of cue exposure training or relapse prevention targeted at substance abuse above a particular level. These behavioral techniques have been incorporated into more comprehensive

Figure 4-5
Teaching Stress Management

The client learns methods that will help her reduce stress, including relaxation techniques, systematic desensitization, planning in advance for a potentially stressful event, and cognitive strategies. These techniques can help in resisting the temptation to abuse substances in otherwise stressful situations. While it does not seem that all clients with substance abuse disorders face increased stress (Cappell, 1987), for those who do, stress management techniques (such as those described by Stockwell, 1995) can prove useful.

Figure 4-6
Programmed Therapy and Writing Therapy

These techniques lend themselves to brief therapy because they reduce the role of the therapist and increase the amount of work required from the client. Phillips and Weiner developed these techniques as stand-alone approaches to treatment (Phillips and Weiner, 1966). However, they can also be used as adjuncts to other forms of treatment and may be incorporated into the homework assignments that many therapists already are using. In programmed therapy, the client interacts with written or computerized instructions and tests that work to teach the client new behaviors, much in the way students might learn a subject from a textbook. Writing therapy involves having the client come in at a designated time each week to write for 1 hour in a notebook which the therapist then reads and responds to in writing. No one but the therapist and the client should have access to the notebook. Writing therapy is a technique that may be particularly useful for clients who have difficulty talking about their thoughts and feelings.

behavioral self-control approaches, even those with an abstinence goal (Larimer and Marlatt, 1990; Sitharthan et al., 1997). The decision to implement such interventions will be guided by the client's continued self-monitoring, which the client and counselor review at each session.

Brief behavioral therapy might also involve the client's spouse or significant others, who may attend several of the therapy sessions. In addition to serving as a corroborator of the client's self-reported substance use, a significant other may be involved in behavioral contracting and community reinforcement interventions. The significant other could be taught to positively reinforce a client's reduced drinking or abstinence and not to argue with her drinking when she is intoxicated, but rather to approach her when she is sober and provide positive feedback. The client and the significant other may develop a contingency contract that will encourage reinforcement of her positive behaviors.

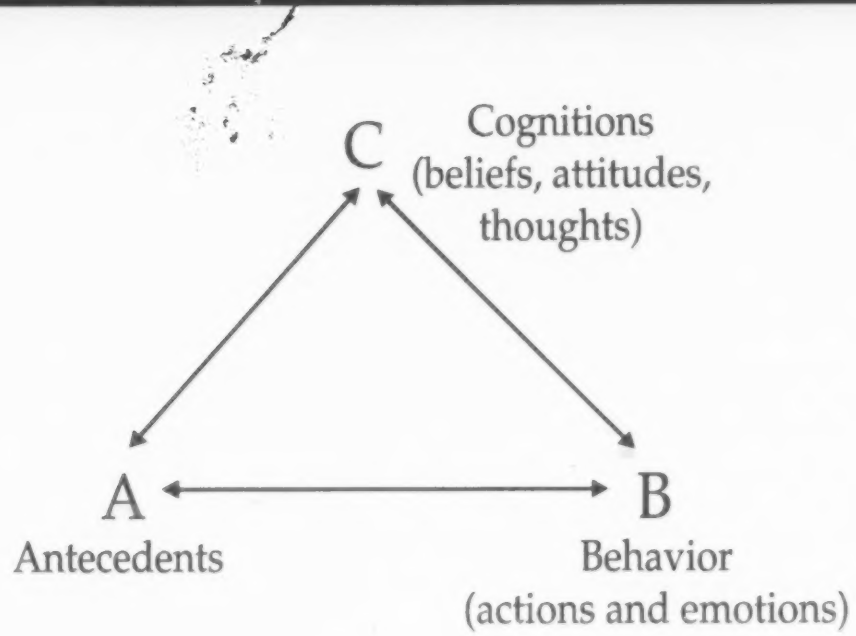
Cognitive Theory

Cognitive theory assumes that most psychological problems derive from faulty thinking processes (Beck and Wright, 1992; Beck et al., 1993; Beck and Liese, 1998; Ellis, 1982; Ellis et al., 1988). The diagram in Figure 4-7 illustrates the three bidirectional components of this theory: (1) cognitions or thoughts, (2) affect or feelings, and (3) behavior. While cognitive theory owes a debt to the behavioral model, the differences are apparent. Unlike behavioral models that focus primarily on observable behaviors, cognitive theory views antecedent events, cognitions, and behavior as interactive and dynamic, as indicated by the double-headed arrows (depicted in Figure 4-7). Each of these components is capable of affecting the others, but the primary emphasis is placed on cognition. The way we act and feel is most often affected by our beliefs, attitudes, perceptions, cognitive schema, and attributions. These cognitive factors serve as a template through which events are filtered and appraised. To the extent that our thinking processes are faulty and biased, our emotional and behavioral responses to what goes on in our life will be problematic. According to this theory, changing the way a client thinks can change the way he feels and behaves.

Cognitive theory was developed by A.T. Beck as a way of understanding and treating depression but has since been applied to numerous other mental health issues including substance abuse disorders. Beck believed that

Figure 4-7

The Relationship Among Factors Maintaining Behavior in Behavioral and Cognitive Models



Antecedents are activating situations or life events (something happens or is about to happen—situations about which the individual has strong feelings). *Cognitions* represent the individual's opinions, thoughts, or attitudes that serve to filter and distort the perception of the antecedents. *Behavior* is the individual's observable actions and emotional reactions that result from his beliefs and emotions (how someone thinks or feels and the behavior resulting from those thoughts).

depressed clients held negative views of themselves, the world, and their future, and that these negative views were the real causes of their depression. He found that their psychological difficulties were due to automatic thoughts, dysfunctional assumptions, and negative self-statements. Automatic thoughts often precede emotions but occur quite rapidly with little awareness; consequently, individuals do not value them highly. For example, depressed people address themselves in highly critical tones, blaming themselves for everything that happens. Figure 4-8 is a list of 15 common cognitive errors found in the thinking processes of individuals with emotional and behavioral problems, including substance abuse disorders. An overview of the nature and content of distorted thinking more specifically associated with substance abuse is provided in Figure 4-9 (Ellis et al., 1988). These thoughts are presumably automatic, overlearned, rigid and inflexible, overgeneralized and illogical, dichotomous, and not based on fact. They also tend to reflect reliance on substances as a means of coping with boredom and negative emotions, a negative view of the self as a person with a substance abuse problem, and a tendency to facilitate continued substance use.

Figure 4-8

Fifteen Common Cognitive Errors

1. *Filtering*—taking negative details and magnifying them, while filtering out all positive aspects of a situation
2. *Polarized thinking*—thinking of things as black or white, good or bad, perfect or failures, with no middle ground
3. *Overgeneralization*—jumping to a general conclusion based on a single incident or piece of evidence; expecting something bad to happen over and over again if one bad thing occurs
4. *Mind reading*—thinking that you know, without any external proof, what people are feeling and why they act the way they do; believing yourself able to discern how people are feeling about you
5. *Catastrophizing*—expecting disaster; hearing about a problem and then automatically considering the possible negative consequences (e.g., "What if tragedy strikes?" "What if it happens to me?")
6. *Personalization*—thinking that everything people do or say is some kind of reaction to you; comparing yourself to others, trying to determine who's smarter or better looking
7. *Control fallacies*—feeling externally controlled as helpless or a victim of fate or feeling internally controlled, responsible for the pain and happiness of everyone around
8. *Fallacy of fairness*—feeling resentful because you think you know what is fair, even though other people do not agree
9. *Blaming*—holding other people responsible for your pain or blaming yourself for every problem
10. *Shoulds*—having a list of ironclad rules about how you and other people "should" act; becoming angry at people who break the rules and feeling guilty if you violate the rules
11. *Emotional reasoning*—believing that what you feel must be true, automatically (e.g., if you feel stupid and boring, then you must be stupid and boring)
12. *Fallacy of change*—expecting that other people will change to suit you if you pressure them enough; having to change people because your hopes for happiness seem to depend on them
13. *Global labeling*—generalizing one or two qualities into a negative global judgment
14. *Being right*—proving that your opinions and actions are correct on a continual basis; thinking that being wrong is unthinkable; going to any lengths to prove that you are correct
15. *Heaven's reward fallacy*—expecting all sacrifice and self-denial to pay off, as if there were someone keeping score, and feeling disappointed and even bitter when the reward does not come

Source: Beck, 1976.

Such negative thoughts and irrational beliefs have been found to be associated with substance abuse disorders. Problem avoidance, dwelling on negative events, holding a negative outlook on the world and on one's future, and avoidance of responsibility have been associated with the development of patterns of substance abuse and urges to drink among individuals with alcohol problems (Butterfield and Leclair, 1988; Denoff, 1988; Rohsenow et al., 1989). Rohsenow and associates found that irrational beliefs—particularly feeling doomed about the past—were predictive of both the frequency of drinking and the average quantity of alcohol consumed following substance abuse treatment (Rohsenow et al., 1989).

Cognitive Therapy

Given the view that dysfunctional behavior, including substance abuse, is determined in large part by faulty cognitions, the role of

Figure 4-9

Characteristic Thinking of People With Substance Abuse Disorders

Qualitative Descriptors

- Automatic, nonconscious
- Rigid, inflexible
- Overlearned and often practiced
- Dichotomous, all-or-none
- Overgeneralized and illogical
- Nonempirical and absolute

Common Content or Themes

- Denial: alcohol or drugs are *not* a problem
- Alcohol or drugs are the *best* and only way to solve emotional problems
- Low frustration tolerance and/or self-defined *needs* for high levels of stimulation, gratification, and excitement
- Discomfort anxiety: *all* negative emotions are to be avoided at all costs
- Change is too difficult, therefore one is hopeless, helpless, worthless
- Self-blame, guilt, and shame for being an addict

Source: Adapted from Ellis et al., 1988.

therapy is to modify the negative or self-defeating automatic thought processes or perceptions that seem to perpetuate the symptoms of emotional disorders. Clients can be taught to notice these thoughts and to change them, but this is difficult at first. Cognitive therapy techniques challenge the clients' understanding of themselves and their situation. The therapist helps clients become more objective about their thinking and distance themselves from it when recognizing cognitive errors or faulty logic brought about by automatic thinking.

Treatment, therefore, is directed primarily at changing distorted or maladaptive thoughts and related behavioral dysfunction. *Cognitive restructuring* is the general term given to the process of changing the client's thought patterns. Figure 4-10 shows a number of distorted addictive thoughts and more rational alternatives that the therapist might help develop and practice over the course of cognitive restructuring.

Once a specific faulty thought is identified, the therapist will challenge a client to look at alternative ways of seeing the same event. Whenever a client has difficulty changing a perception, the therapist can give him homework to test the truth of his cognitions. If, for example, a client insists that his boss hates him, the therapist can ask him to verify this with an assignment: "Ask your coworkers if your boss treats them the same way he treats you." Figure 4-11 gives an example of how a thought leads to a feeling and then to a behavior.

Once the maladaptive thoughts are discovered in a person's habitual, automatic thinking, it becomes possible to modify them by substituting rational, realistic ideas for the distorted ones to create a happier and healthier life without substance abuse.

The approach developed by Beck and colleagues to achieve the goal of a substance-free life is referred to as cognitive therapy (Beck et al., 1993; Beck and Liese, 1998), while Ellis' approach is known as rational-emotive therapy

Figure 4-10
Common Irrational Beliefs About Alcohol and Drugs
With More Rational Alternatives

Irrational Belief	Rational Alternative or Dispute
Drinking is never a problem for me, even if I do lose control once in a while. It's other people who have a problem with the way I drink.	Losing control can be the first sign of a problem, and if my drinking is a significant problem for others, sooner or later it will be for me.
I *need* to use drugs to relax.	I want to use drugs but don't have to use them just because I want to.
I can't stand not having what I want; it is just *too* hard to tolerate.	I may not like it, but I have stood it in the past and can do so now.
The only time I feel comfortable is when I'm high.	It's hard to learn to be comfortable socially without drugs but people do so all the time.
It would be too hard to stop drinking. I'd lose all my friends, be bored, and never be comfortable without it.	While stopping drinking and doing drugs might cost me some things and take time and effort, if I don't, the consequences will be far worse.
People who can't or don't drink are doomed to frustration and unhappiness.	Where's the evidence of that? I'll try going to an Alcoholics Anonymous meeting and do some research on how frustrated and miserable these nondrinkers actually are.
Once you've stopped using and you see it's all over, you're right back to where you started, and all your efforts only lead you to total failure. Once an addict, always an addict.	A slip is only a new learning experience toward recovery. It is not a *failure*, only a setback that can tell me what direction I need to go in now. It's my choice.

Source: Adapted from Rotgers, 1996.

(Ellis et al., 1988). Generally, the therapist takes a more active role in cognitive therapy than in other types of therapy, depending on the stage of treatment, severity of the substance abuse, and degree of the client's cognitive capability.

While Ellis and Beck have similar views about the prominent role that cognitions play in the development and maintenance of substance abuse disorders, their theories differ in considering how the therapist should treat irrational or maladaptive cognitions. Rational-emotive therapy is often more challenging and confrontative, with the therapist informing the client of the irrationality of certain types of beliefs that all people are prone to. Beck, on the other hand, believes that the cognitive therapist, using a supportive Socratic method, should enlist the client in carefully examining the accuracy of her beliefs. Thus, Beck places more importance on the client's own discovery of faulty and unproductive thinking, while Ellis believes that the client should simply be told that these exist and what they are. Nevertheless, there is substantial overlap in both the theory and practice of these two therapies. Clearly, different clients will have different responses to these qualitatively different approaches to modifying their thoughts and beliefs.

Figure 4-11
Thoughts, Feelings, and Behaviors

Thought	*Feeling*	*Behavior*
"There's only one way to feel really good"	Desire to feel good	Drink alcohol, snort cocaine
The maladaptive thought in this triad should be replaced in order to avoid the consequent behavior.		
"I can feel good by jogging or taking a walk, or..."	Desire to feel good	Walking, running

Source: Adapted from Rotgers, 1996.

Therapeutic work in cognitive therapy is devoted primarily, although not exclusively, to addressing specific problems or issues in the client's present life, rather than global themes or long-standing issues. At times, however, it is important to understand the connection between the origins of a set of cognitions and the client's current behavior. Such an understanding of how the individual got to the present emotional and behavioral state is often essential to understanding the mechanism of change. The client's attention to current problems is intended to promote her development of a plan of action that can reverse dysfunctional thought processes, emotions, and behavior—such as avoidance of problems or feelings of helplessness. Clients are enlisted as coinvestigators or scientists who study their own thought patterns and associated consequences.

Cognitive therapy can be useful in the treatment of substance abuse disorders in several ways. When distorted or unproductive ways of thinking about daily life events lead to negative emotional states that then promote substance use, cognitive therapy can be used to alter the sequence by targeting and modifying the client's thoughts. When clients limit their options for coping with stress by rigid or all-or-nothing thinking (e.g., "nothing will help me deal with this problem but a drink"), cognitive therapy can help them explore alternative behaviors and attitudes that do not involve the use of substances. In addition, cognitive therapy can help the client develop healthier ways of viewing both his history of substance abuse and the meaning of a recent "slip" or relapse so that it does not inevitably lead to more substance abuse.

Initial Session

Cognitive therapy works under the assumption that a client can be educated to approach his problems rationally. Because of this emphasis on rational understanding, the cognitive therapist will typically begin therapy by explaining the nature of her approach (see Figure 4-12 for a sample opening script).

In the opening session of cognitive therapy, the therapist will assess the client's view of his problems and their causes. The therapist pays careful attention to the meaning the client assigns to significant events and how that meaning is related to subsequent feelings and unwanted behavior. In the middle to late phases of the first session, the therapist will emphasize the collaborative aspect of the therapy process and introduces the cognitive model to the client. There are three major steps in this process:

1. The therapist establishes rapport by listening carefully to the client, using questions and reflective listening to try to understand how the client thinks about his

Figure 4-12

Introducing Cognitive Therapy: A Sample Script

"I want to spend a few minutes telling you about my approach. Basically, it comes from the observation by many people that our feelings and behaviors in particular situations follow directly from how we think about these situations. My goal in working with you is to focus on trying to understand how you see things—the important things in your life that are related to substance use—and to help you look at them objectively and honestly. We may find that you are seeing them correctly, and we'll have to address these realities. Sometimes, though, people get into automatic ways of thinking about themselves and their situation without examining them more carefully. Let's look at these possibilities and see if they can be changed to help you. How does that sound to you?"

life circumstances and how those thoughts relate to problematic feelings and behavior. The client educates the therapist about himself and his problems.

2. The therapist educates the client about the cognitive model of therapy and determines if he is satisfied with the model.
3. The therapist asks the client to describe a recent event that has triggered some recent negative feelings, as a way of illustrating the cognitive therapy process.

Later Sessions

Cognitive therapy tends to follow a standard within-session structure to make the maximum use of time, to focus on the most important current problems, to set the tone for a working atmosphere, and to maintain continuity between sessions. Beck structures sessions into eight elements, listed below, which he describes in greater detail (Beck et al., 1993):

1. *Setting the agenda*—to focus on primary goals for treatment
2. *Mood check*—to monitor the feelings of the client, especially changes
3. *Bridge from last session*—to maintain continuity between sessions
4. *Discussion of today's agenda*—to prioritize topics, avoid irrelevant tangents, determine the best possible use of time, and solicit the client's topics for discussion
5. *Socratic questioning*—to encourage the client to contemplate, evaluate, and synthesize diverse sources of information; also known as "guided discovery"
6. *Capsule summaries*—to maintain focus and a connection to the goals of the therapy
7. *Homework assignments*—to serve as a bridge between sessions and to ensure that the client continues to work on problems by collecting information, testing beliefs, and trying new behaviors
8. *Feedback in the therapy sessions*—to ensure that the client and therapist are communicating

Duration of Therapy and Frequency of Sessions

Cognitive therapy adheres to the basic goals of planned brief therapy, but treatment times can vary. It typically lasts from 12 to 20 weeks, with the client and therapist meeting once per week. (Freeman et al., 1990). However, it can be conducted in less time—for instance, once per week for six to eight sessions. The number of sessions will depend on the nature of the problem.

Because cognitive therapy is usually planned for comparatively short treatment times, there has not been much research to study the relative effectiveness of longer term cognitive therapy. However, Lyons and Woods in their meta-analysis of 70 different rational-emotive therapy

studies found that increased effects correlated with longer treatment times (Lyons and Wood, 1991). More research needs to be conducted looking at the effect of treatment duration on the efficacy of these therapies.

In a brief version of this therapy, there is less time to understand and restructure all of the cognitions that may be influencing substance abuse. The therapist must use the early sessions to determine the most productive focus of the therapy, given the short timeframe. If the client used substances primarily to cope with negative mood states, then therapy may focus on understanding how the client's interpretation of events led to the negative moods. Restructuring these thought processes may help decrease reasons for substance abuse. Alternatively, if the client drinks largely to party and have a good time with friends, a focus on expected effects may lead to the client's gaining greater awareness of negative consequences and, perhaps, a reduced association of the substance with positive experiences. If the client is returning to therapy after a period of sobriety that ended in relapse, a focus on the circumstances leading to relapse and other resulting consequences may shape the therapy.

A number of specific cognitive therapy techniques may be appropriate for use, depending on the phase of treatment and the issues raised by the client. Cognitive interventions can be introduced at any point throughout the treatment process, whenever the therapist feels it is important to examine a client's inaccurate or unproductive thinking that may lead to the risk of substance abuse. They also can be used episodically with clients who leave and then return to treatment or during aftercare or continuing care following a more intensive treatment episode.

Periods without therapy sessions allow clients time to practice the new skills of identifying and challenging unproductive thinking on their own. However, it is easy to fall back into old, automatic ways of thinking that may require a return to therapy. The therapist can productively build on what was learned in previous sessions, help the client see how she slipped into old patterns, and further reinforce the process of catching oneself in the process of thinking negative automatic thoughts. The therapist must be prepared to move from topic to topic while always adhering to the major theme—that how the client thinks determines how the client feels and acts, including whether the client abuses substances.

Cognitive therapy can be quite successful as an option for brief therapy for several other reasons (Carroll, 1996a):

- It is designed to be a short-term approach suited to the resource capabilities of many delivery systems.
- It focuses on immediate problems and is structured and goal oriented.
- It is a flexible, individualized approach that can be adapted to a wide range of clients, settings (both inpatient and outpatient), and formats, including groups.

Cognitive–Behavioral Theory

Early behavioral theories of substance abuse were nonmediational in nature (Donovan and Marlatt, 1993). They focused almost exclusively on overt, observable behaviors, and it was believed that understanding the antecedents and reinforcement contingencies was sufficient to explain behavior and to modify it. Over time, however, these behavioral theories began to incorporate cognitive factors into their conceptualizations of substance abuse disorders. These more recent models are mediational in nature; that is, a greater role is attributed to the interaction among a variety of individual difference variables such as beliefs, values, perceptions, expectations, and attributional processes in mediating the development and

continuation of substance abuse disorders (Abrams and Niaura, 1987; Mackay and Donovan, 1991; Marlatt et al., 1988; Marlatt and Donovan, 1981). This expanded, mediational model has been described as cognitive social learning or cognitive–behavioral theory. This theory postulates that cognitive factors mediate all interactions between the individual, situational demands, and the person's attempts to cope effectively.

Cognitive–behavioral theory represents the integration of principles derived from both behavioral and cognitive theories, and it provides the basis for a more inclusive and comprehensive approach to treating substance abuse disorders. However, a broader range of cognitions is included in cognitive–behavioral theory than had been involved in earlier versions of cognitive theory. These include attributions, appraisals, self-efficacy expectancies, and substance-related effect expectancies. Each of these will be reviewed briefly below. Common elements of brief cognitive–behavioral therapy are listed in Figure 4-13.

Attributions

An attribution is an individual's explanation of why an event occurred. Abramson and colleagues proposed that individuals develop attributional styles (i.e., individual ways of explaining events in their lives that can play a role in the development of emotional problems and dysfunctional behaviors) (Abramson et al., 1978). The basic attributional dimensions are internal/external, stable/unstable, and global/specific. For instance, clinically depressed persons tend to blame themselves for adverse life events (internal), believe that the causes of negative situations will last indefinitely (stable), and overgeneralize the causes of discrete occurrences (global). Healthier individuals, on the other hand, view negative events as due to external forces (fate, luck, environment), as having isolated meaning (limited only to specific events), and as being transient or changeable (lasting only a short time). Figure 4-14 lists and further defines the three dimensions of attribution that make up an "attributional style."

Attributional styles play a major role in the cognitive–behavioral theory of substance abuse disorders (Davies, 1992; Marlatt and Gordon, 1985). The nature of substance abusers' attributional styles is thought to have considerable bearing on their perception of their substance abuse problem and their approach to recovery. An alcohol-dependent client, for instance, may believe that he drank because he was weak (an internal attribution) or because he was surrounded by people encouraging him to have a beer (an external attribution). He may believe that his failure to maintain abstinence shows that he is a weak person who can never succeed at anything (a global attribution) or that a drinking episode does not represent a general weakness, but was instead due to the specific circumstances of the moment (a specific

Figure 4-13

Common Elements of Brief Cognitive–Behavioral Therapies

- The therapist focuses on current problems.
- She establishes attainable and contracted goals.
- She seeks to obtain quick results for the most pressing problems.
- She relies on a variety of empirically based techniques to increase the client's ability to handle his own problems.

Source: Adapted from Bloom, 1997; Peake et al., 1988.

Figure 4-14

Attributional Styles

Internal/External:	Do you attribute events and their causes to yourself or to others?
Stable/Unstable:	Will this cause continue to affect your future or can it change or stop?
Global/Specific:	Does the cause of one bad circumstance affect all areas of your life or just one?

attribution). He may believe that the cause of his slip is something he cannot change (a stable attribution) or that the next time, he will catch himself and exert better coping responses (an unstable attribution). Whereas the internal, global, and stable attribution for the use of alcohol is likely to lead to feelings of hopelessness and a return to drinking, the external, specific, unstable attribution is likely to lead to greater efforts to cope with similar situations in the future.

Marlatt and Gordon described a negative attributional process that can occur after a slip (the first use of a substance after a period of abstinence) and that may lead to continued use in a full-blown relapse (Marlatt and Gordon, 1985). This process, known as the *abstinence violation effect* (AVE), involves the attribution of the cause of an initial slip to internal, stable, and global factors. These clients may believe that they are hopeless addicts and failures, that they will never be able to achieve and maintain sobriety, and that there is no use in trying to change because they think that they cannot succeed.

AVE also has an emotional component associated with it. Substance abusers who have slipped and have internal, stable, and generalized attributions will feel depressed, worthless, helpless, and hopeless. This attributional style tends to be associated with a form of "learned helplessness" that is perpetuated by the substance users' distorted perceptions. Together, the sense of helplessness and the negative emotional state increase the likelihood that the initial lapse will develop into a full-blown relapse. Research with individuals dependent on alcohol, marijuana, opiates, and other illicit drugs, provides empirical support for the attributional style hypothesized to mediate the AVE (Birke et al., 1990; Bradley et al., 1992; Reich and Gutierres, 1987; Stephens et al., 1994; Walton et al., 1994).

Cognitive Appraisal

For the cognitive–behavioral therapist, an individual's appraisal of stressful situations and his ability to cope with the demands of these situations are important influences on the initiation and maintenance of substance abuse, as well as relapse after cessation of use (Hawkins, 1992; Marlatt and Gordon, 1985; Shiffman, 1987, 1989; Wills and Hirky, 1996).

Folkman and Lazarus described two different levels of cognitive appraisal (Folkman and Lazarus, 1988, 1991). The first level is a primary appraisal. This represents the individual's perception of a situation and an estimation of the potential level of stress, personal challenge, or threat involved with the situation. Secondary appraisal represents the individual's evaluation of her ability to meet the challenges and demands specific to the situation. This secondary appraisal, which will be influenced by the extent, nature, and availability of the individual's coping skills, further mediates the individual's perception of stress and the person's emotional response.

To the extent that the individual senses that she has the necessary behavioral, cognitive, or emotional coping skills to meet the challenges of the situation, it will be appraised as less threatening or stressful. Conversely, if the person judges that the necessary coping skills

are lacking, the situation is viewed as more threatening and stressful, and the person is likely to be frightened, anxious, depressed, or helpless. The results of Smith and colleagues suggest that such cognitive appraisals may play a more prominent role than attributions in mediating emotional responses to potentially threatening situations (Smith et al., 1993).

Coping behaviors

In substance use-related situations, *coping* "refers to what an individual does or thinks in a relapse crisis situation so as to handle the risk for renewed substance use" (Moser and Annis, 1996, p. 1101). Cognitive–behavioral theory posits that substance users are deficient in their ability to cope with interpersonal, social, emotional, and personal problems. In the absence of these skills, such problems are viewed as threatening, stressful, and potentially unsolvable. Based on the individual's observation of both family members' and peers' responses to similar situations and from their own initial experimental use of alcohol or drugs, the individual uses substances as a means of trying to deal with these problems and the emotional reactions they create. From this perspective, substance abuse is viewed as a learned behavior having functional utility for the individual—the individual uses substances in response to problematic situations as an attempt to cope in the absence of more appropriate behavioral, cognitive, and emotional coping skills.

A number of dimensions are involved in the coping process as it relates to substance abuse (Donovan, 1996; Hawkins, 1992; Lazarus, 1993; Shiffman, 1987; Wills and Hirky, 1996). The first is the general domain in which the coping response occurs. Coping responses can occur within the affective, behavioral, and cognitive domains. Litman identified a number of behavioral and cognitive strategies that are protective against relapse (Litman, 1986). There are two behavioral classes of coping behavior: (1) basic avoidance of situations that have been previously associated with substance abuse and (2) seeking social support when confronted with the temptation to drink or use drugs.

The cognitive domain also includes two general categories of coping: (1) negative thinking, or thinking about all the negative consequences that have resulted from substance abuse and a desire to no longer experience these, and (2) positive thinking, or thinking about all the benefits that are accrued by being clean and sober and not wanting to lose these. Litman suggests that these coping strategies operate in a somewhat sequential manner (Litman, 1986). Initially, when clients are attempting to initiate and stabilize abstinence from substances, they appear to rely more heavily on the behavioral strategies. As the period of abstinence increases, there appears to be a transition from predominantly behavioral strategies toward a greater reliance on cognitive methods of coping.

Coping strategies have a number of other dimensions. They can be emotion focused, problem focused, or avoidant. A distinction is also made between those that are general coping strategies and those that are expressly attempting to cope with urges, craving, and temptation to use in settings associated with past substance abuse. Another important dimension of coping strategies is the stage at which they are used in response to a potentially difficult substance-related situation (Shiffman, 1989). Anticipatory coping is employed as one anticipates and attempts to plan how to deal with upcoming situations. They take the form of "What can I do if...." There are also coping strategies that are employed in the moment that one is having to deal with the difficult substance-related situations. They take the form of "What can I do now...." Finally, there are restorative coping strategies that can be employed if one fails to cope and finds himself using in the situation. These take the form of "What can I do now that I've..." It is these

restorative coping strategies that play a role in determining whether an initial drink or use of drugs will escalate into a full-blown relapse.

Research on coping behavior as it relates to substance abuse disorders has generally supported the basic tenet of cognitive–behavioral approaches, namely that these clients are deficient in their coping skills, that these deficiencies contribute to their continued substance abuse, and that those whose deficits are not remedied are at a greater risk of relapse than those who increase their coping through treatment (Wills and Hirky, 1996). Another study found that the number of coping attempts and the type of coping will influence both relapse and the return to abstinence (Moser and Annis, 1996). Attempting to cope with a relapse crisis led to higher rates of abstinence than not trying to cope, and the greater the number of coping strategies employed, the less likely the person was to use. If one coping response was performed, the probability of abstinence was 40 percent; the probability rose to 80 percent if two coping attempts were made. Similarly, the greater the number of coping strategies used by an individual following a relapse, the greater the likelihood of returning to abstinence. Exclusive use of active coping strategies (e.g., engaging in alternative activities that are incompatible with drinking, problemsolving, seeking support from others, thinking of consequences of using, using positive/negative self-talk) was associated with maintaining abstinence in contrast to exclusive reliance on avoidant strategies (e.g., ignoring the situation, dealing with it indirectly by eating, or relying on willpower).

Neidigh and colleagues investigated the strategies employed to cope with stress and the temptation to drink among individuals attempting to control their drinking (Neidigh et al., 1988). They found that both cognitive and behavioral coping strategies were effective in resisting a drink. Two other important findings were obtained. First, there appears to be a considerable degree of situational specificity in the coping process. That is, different types of substance-related situations seem to require different types of coping responses rather than a general coping strategy's being equally effective across situations. Second, strategies used to cope with nonspecific stress appear to be somewhat different from those used to cope with temptation. These findings suggest that treatment not only should rectify deficiencies in coping abilities, but that it may be necessary to focus on skills to deal with both general stress and substance-related temptation. Furthermore, it may be necessary to develop coping skills specific to several possible situations in which the client may use substances.

Self-Efficacy Expectancies

The apparent lack of coping skills among substance users is an important contributor to another key construct in cognitive–behavioral approaches, namely self-efficacy expectancies (Bandura, 1977). These expectancies refer to an individual's beliefs about his ability to successfully execute an appropriate response in order to cope with a given situation. Self-efficacy expectancies are determined in part by the individual's repertoire of coping skills and an appraisal of their relative effectiveness in relation to the specific demands of the situation. Bandura has hypothesized that expectations of personal efficacy determine whether coping behavior will be initiated or not, the amount of effort that will be expended in attempting to cope, and how long a coping attempt will continue in the face of obstacles and aversive experiences (Bandura, 1977). He also suggested that self-efficacy exerts an influence on the individual's behavior through cognitive, motivational, and emotional systems (Bandura, 1994). If a person has low self-efficacy due to a lack of necessary coping skills, she might be expected to have negative or distorted thoughts and beliefs about herself and her situation, have

reduced motivation to even try to cope, and may be depressed and perceive herself as helpless.

Cognitive–behavioral approaches to substance abuse disorders postulate that low levels of self-efficacy are related to substance use and an increased likelihood of relapse after having achieved abstinence (Annis and Davis, 1988b, 1989b; DiClemente and Fairhurst, 1995; Marlatt and Gordon, 1985). A model of relapse that is based on the role of self-efficacy and coping is depicted in Figure 4-15.

Self-efficacy has been thought of as both the degree of a client's temptation to use in substance-related settings and his degree of confidence in his ability to refrain from using in those settings (Annis and Davis, 1988b; DiClemente et al., 1994; Sklar et al., 1997). The role of self-efficacy has been examined for alcohol (Evans and Dunn, 1995; Solomon and Annis, 1990), cocaine (Coon et al., 1998; Rounds-Bryant et al., 1997), marijuana (Stephens et al., 1993), opiates (Reilly et al., 1995), and across all of these substances of abuse (Sklar et al., 1997). This research generally supports the hypothesis that those with lower levels of self-efficacy are more likely to abuse substances.

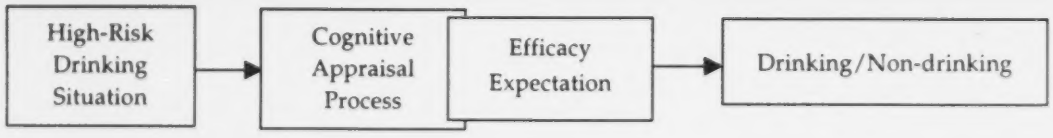
Substance-Related Effect Expectancies

As substance use is reinforced by the positive effects of the substance being taken, it is also likely that the individual will develop a set of cognitive expectancies about these anticipated effects on her feelings and behavior. They represent the individual's expectation that certain effects will predictably result from substance use. Although there has been more research on alcohol-related effect expectancies (Goldman, 1994), there has been an increased interest in drug-related expectancies (Brown, 1993). Given that drugs have differing effects, it has been necessary to develop measures specific to the effects anticipated from these different drugs, such as marijuana (Schafer and Brown, 1991) and cocaine (Jaffe and Kilbey, 1994; Schafer and Brown, 1991).

The initial focus in studying alcohol-related expectancies was on the positive effects that individuals anticipated from alcohol (Goldman and Brown, 1987). Drinkers anticipated that alcohol would serve as a global elixir, having positive effects on mood, social and interpersonal behavior, sexual behavior, assertiveness, and tension reduction. Positive effect expectancies for marijuana include relaxation and tension reduction, social and sexual facilitation, and perceptual and cognitive enhancement (Schafer and Brown, 1991). Positive cocaine-related expectancies include global positive effects, generalized arousal, euphoria, enhanced abilities, and relaxation and tension reduction (Jaffe and Kilbey, 1994; Schafer and Brown, 1991).

More recently, there has been an increased interest in the expectations of negative outcomes that individuals hold about substances. Negative expectancies about alcohol include cognitive and behavioral impairment, risk and

Figure 4-15
Relapse Prevention Model Based on Self-Efficacy Theory



Source: Annis and Davis, 1991, p. 205.

aggression, and negative self-perception (Fromme et al., 1993). Negative consequences expected from cocaine include global negative effects, anxiety, depression, and paranoia (Jaffe and Kilbey, 1994; Schafer and Brown, 1991). It is thought that the anticipated positive effects of substances serve as an incentive or motivation to use. Conversely, negative expectancies are thought to act as a disincentive and contribute to reduced drinking or drug use (McMahon and Jones, 1993; Michalec et al., 1996).

Research supports these hypothesized actions of positive and negative expectancies (Jaffe and Kilbey, 1994; Jones and McMahon, 1994b; Rounds-Bryant et al., 1997). Positive alcohol- and cocaine-related expectancies are associated with a greater likelihood of relapse and poorer substance-related outcomes (Brown et al., 1998; Rounds-Bryant et al., 1997), whereas negative alcohol effect expectancies are related to decreased likelihood of relapse and less alcohol consumption (Jones and McMahon, 1994a; McMahon and Jones, 1996).

Research also indicates that alcohol-related effect expectancies were negatively correlated with clients' ratings of self-efficacy at the beginning of treatment (Brown et al., 1998); that is, the lower the perceived self-efficacy, the greater the level of anticipated positive effects of alcohol. Both these sets of expectancies changed over the 4-week course of treatment, with self-efficacy increasing and alcohol effect expectancies decreasing. Lower self-efficacy judgments, positive alcohol expectancies, and reliance on avoidant, emotion-focused coping strategies were significantly associated with increased alcohol consumption and alcohol-related problems among heavy drinking college students (Evans and Dunn, 1995).

High-Risk Situations

Over time, with repeated exposure, aspects of a situational context (e.g., the people, places, feelings, activities) can come to serve as conditioned cues that can elicit a strong craving or desire to use. To the extent that substance abuse allows the individual to avoid or escape such problem situations or their resultant emotional reactions, the use of substances will be reinforced through operant learning. Thus the likelihood is increased that substances will be abused and will come to be relied on in the future when the individual encounters similar situations.

Marlatt and colleagues have characterized a number of situations in which substances are abused (Chaney et al., 1982; Cummings and Gordon, 1980; Marlatt and Gordon, 1980, 1985). While the original taxonomy of these situations focused on settings in which relapse occurred following a period of abstinence from a substance, the settings appear to represent situations in which substance use in general will be more likely to occur (Annis and Davis, 1988a; Marlatt, 1996). The situations as originally categorized are found in Figure 4-16.

These situations have been classified into categories. At the broadest level, they are considered either interpersonal (i.e., involving a present or recent interaction with someone else) or intrapersonal–environmental (i.e., factors that are either internal to the individual or reactions to nonpersonal environmental events). There are a number of more specific situations within each of these broader categories. These situations include many emotional, interpersonal, and environmental settings in which people commonly abuse substances and where they are likely to relapse. Therefore, these are called "high-risk" situations. These situations also serve as the foundation from which a number of measures of substance-related self-efficacy have been developed (Annis and Davis, 1988b; DiClemente et al., 1994; Sklar et al., 1997).

While there appears to be considerable overlap in high-risk situations across substances (Cummings and Gordon, 1980), there are also a

Figure 4-16
Taxonomy of High-Risk Situations Based on Marlatt's Original Categorization System

Intrapersonal–Environmental Determinants

- Coping with negative emotional states
  - Coping with frustration and anger
  - Coping with other negative emotional states (e.g., fear, anxiety, tension, depression, loneliness, sadness, boredom, grief, loss, guilt)
- Coping with negative physical/physiological states
  - Coping with physical states associated with prior substance use (e.g., withdrawal distress)
  - Coping with other negative physical states (e.g., pain, illness, injury, fatigue)
- Enhancement of positive emotional states (e.g., using substances to enhance pleasure, for celebration)
- Testing personal control (e.g., using to test "willpower" to see if treatment worked, to see if one can drink or use in a moderate way)
- Giving in to temptations or urges
  - In the presence of substance-related cues
  - In the absence of substance-related cues

Interpersonal Determinants

- Coping with interpersonal conflict
  - Coping with frustration and anger
  - Coping with other interpersonal conflict
- Social pressure to drink or use
  - Direct social pressure
  - Indirect social pressure
- Enhancement of positive emotional states

Source: Marlatt, 1996.

number of substance-specific patterns. Emotional and situational risk factors have been examined among a clinical sample of individuals who were primary abusers of alcohol, cocaine, marijuana, sedatives and tranquilizers, or heroin/opiates. They found that positive social experiences and negative emotional states were important risk factors for patients who were dependent on alcohol or cocaine. Positive emotional and situational factors were most important for those using marijuana. Individuals dependent on sedatives and tranquilizers or heroin/opiates reported that negative physical states and interpersonal conflict were the most important risk factors. Again, it is the individual's appraisal of such situations, in terms of its threat to maintaining abstinence relative to their available coping abilities, that determines the situational risk for the individual (Myers et al., 1996).

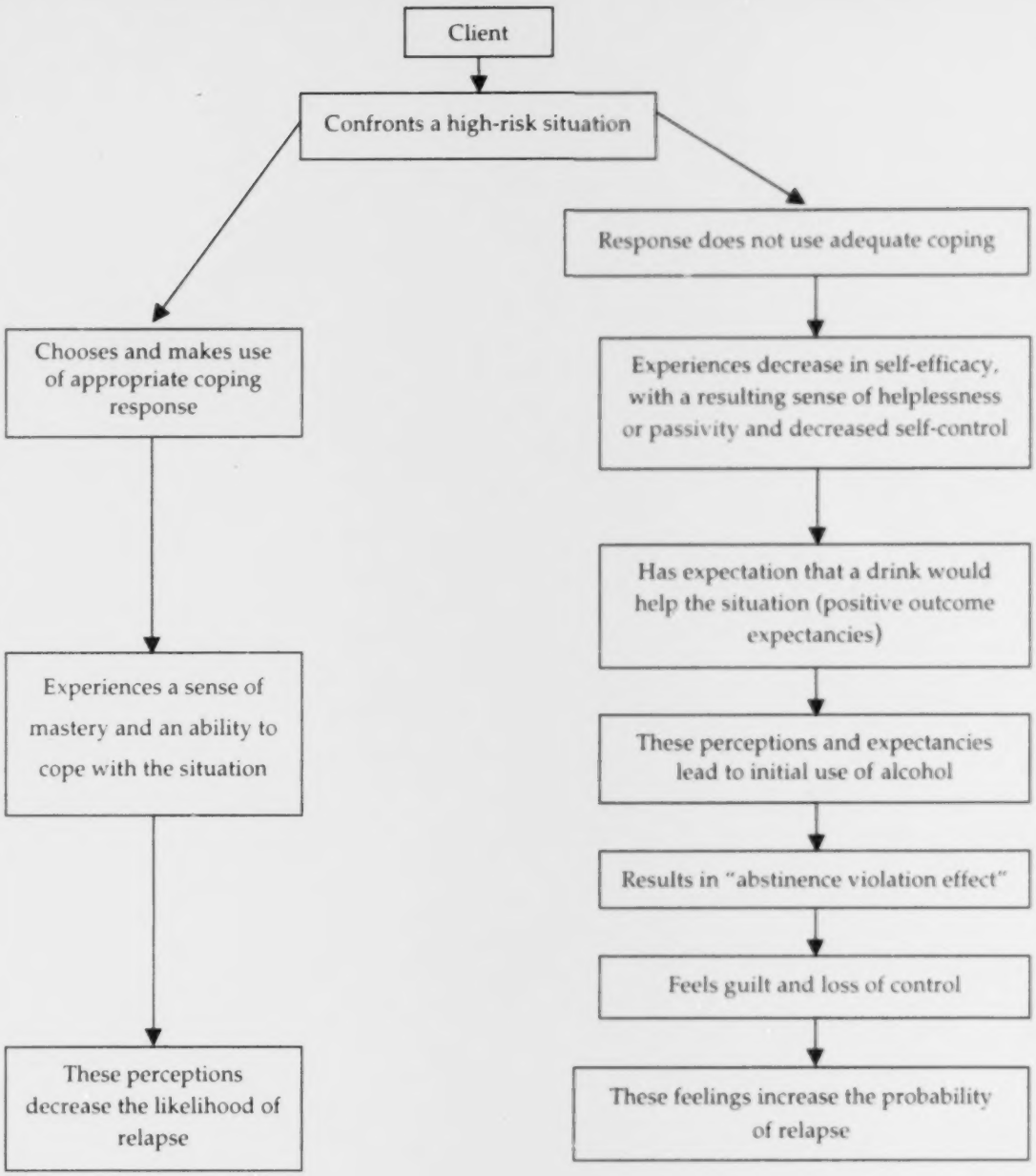
The Cognitive–Behavioral Approach to Substance Abuse Disorders

The cognitive–behavioral approach attempts to integrate all of these theoretical details into a meaningful model of substance abuse disorders (Mackay et al., 1991; Marlatt et al., 1988). Figure 4-17 presents a flowchart that depicts this model of substance abuse and dependence.

The cognitive–behavioral model assumes that substance abusers are deficient in coping

Figure 4.17

A Cognitive-Behavioral Model of the Relapse Process


Client
Confronts a high-risk situation
Chooses and makes use of appropriate coping response
Experiences a sense of mastery and an ability to cope with the situation
These perceptions decrease the likelihood of relapse
Response does not use adequate coping
Experiences decrease in self-efficacy, with a resulting sense of helplessness or passivity and decreased self-control
Has expectation that a drink would help the situation (positive outcome expectancies)
These perceptions and expectancies lead to initial use of alcohol
Results in "abstinence violation effect"
Feels guilt and loss of control
These feelings increase the probability of relapse

Source: Adapted from Kadden, 1995.

skills, choose not to use those they have, or are inhibited from doing so (Monti et al., 1994, 1995). It also assumes that over the course of time, substance abusers develop a particular set of effect expectancies based on their observations of peers and significant others abusing substances to try to cope with difficult situations and through their own experiences of the positive effects of substances. They have come to believe that substances have positive benefits that are more immediate and prominent than their negative consequences. They also come to rely on substances as a means of trying to cope with these situations.

To the extent that the individual is lacking in the coping skills necessary to deal with the demands of high-risk substance abuse or relapse situations, his sense of self-efficacy decreases. As personal efficacy decreases, the anticipated positive effects of substance abuse increase and become more salient (Brown et al., 1998). Under such conditions, the individual is likely to use (Moser and Annis, 1996). When confronted by similar situations in the future, the likelihood of using continues to be quite high, unless new coping skills have been learned. Given the interaction of self-efficacy, substance-related effects expectancies, and high-risk situations, "the decision to drink or exercise restraint (self-control) is ultimately determined by self-efficacy and outcome expectations formulated around a current situational context" (Abrams and Niaura, 1987, p. 152).

Attributional processes and emotional responses also play a role in an individual's decision to use (Marlatt and Gordon, 1985). Should the client attribute her substance abuse to internal, stable, and global characteristics (e.g., "I'm nothing but an addict; there's nothing that I can do to stop using"), then it is likely that she will feel angry, depressed, hopeless, and helpless. These reactions are less likely to occur and to be less pronounced for individuals who are more firmly committed to the goal of abstinence or moderation and for those who have maintained such goals longer. These negative emotions represent yet another high-risk situation. If the individual does not have the necessary restorative coping skills to deal with them and to counteract the impact of a negative attributional style, it is more likely that an initial slip will continue on as a full-blown relapse (Stephens et al., 1994).

Cognitive–Behavioral Therapy

Cognitive–behavioral therapy (CBT) derives, in part, from both behavioral and cognitive theories. While sharing a number of procedures in common, CBT is also distinct in many ways from these other therapies (Carroll, 1998). In comparison to cognitive therapy, CBT places less emphasis on identifying, understanding, and changing underlying beliefs about the self and the self in relationship to substance abuse. It focuses instead on learning and practicing a variety of coping skills, only some of which are cognitive. A greater emphasis is also placed on using behavioral coping strategies, especially early in therapy. CBT tries to change what the client both does and thinks.

In comparison to behavioral treatments such as the community reinforcement approach, CBT focuses more on cognitions, beliefs, and expectancies. Also, CBT generally does not incorporate contingency management approaches such as the use of vouchers to reinforce desired behaviors. CBT is usually confined to the treatment session (although therapists often give homework to clients to be completed outside the therapy session), whereas the community reinforcement approach stresses the importance of incorporating interventions into real world settings and taking advantage of community resources. Figure 4-18 lists a number of features thought to be unique to cognitive–behavioral interventions.

Figure 4-18

Essential and Unique Elements of Cognitive–Behavioral Interventions

The key ingredients that distinguish CBT from other some other therapies and that must be included in a CBT treatment include the following:

- A functional analysis of substance abuse
- Individualized training in recognizing and coping with craving, managing thoughts about substance abuse, problemsolving, planning for emergencies, recognizing seemingly irrelevant decisions, and using refusal skills
- An examination of the client's cognitive processes related to substance abuse
- The identification and debriefing of past and future high-risk situations
- The encouragement and review of extra-session implementation of skills
- Practice of skills within sessions

Source: Carroll, 1998.

CBT uses learning processes to help individuals reduce their drug use. It works by helping clients recognize the situations in which they are likely to use, find ways of avoiding those situations, and cope more effectively with situations, feelings, and behaviors related to their substance abuse (Carroll, 1998). To achieve these therapeutic goals, cognitive–behavioral therapies incorporate three core elements: (1) functional analysis, (2) coping skills training, and (3) relapse prevention (Rotgers, 1996).

Functional Analysis

Behavioral, cognitive, and cognitive–behavioral treatments all rely heavily on an awareness of the antecedents and consequences of substance abuse. In all of these therapeutic approaches, the client and therapist typically begin therapy by conducting a thorough functional analysis of substance abuse behavior (Carroll, 1998; Monti et al., 1994; Rotgers, 1996). This analysis attempts to identify the antecedents and consequences of substance abuse behavior, which serve as triggering and maintaining factors. Antecedents of use can come from emotional, social, cognitive, situational/environmental, and physiological domains (Miller and Mastria, 1977). The functional analysis should also focus on the number, range, and effectiveness of the individual's coping skills. While a major emphasis in cognitive–behavioral therapy is on identifying and remediating deficits in coping skills, it is also important to assess the client's strengths and adaptive skills (DeNelsky and Boat, 1986).

The functional analysis will also assess features in the client's emotional states and thoughts and in her environment that are highly associated with substance abuse. This allows the identification of situations that are particularly high risk for the individual. In addition, it is important to determine what the person thought, felt, and did both during and after high-risk situations. Gaining information about high-risk situations in which the person drank or used drugs and those in which a relapse crisis was encountered but averted is helpful in assessing coping abilities, self-efficacy perceptions, substance-related effect expectancies, and attributional processes.

Without such a thorough assessment, CBT treatment cannot proceed and is likely to fail (Rotgers, 1996). This detailed analysis serves to inform the treatment process and individualize the specific interventions and treatment plan for the client. The therapist and client can then use the results of the functional analysis to

anticipate high-risk situations and develop specific methods to avoid or cope with them.

Questionnaires, interviews, and role-playing measures are available to assist the therapist in the assessment and functional analysis. The therapist should try to evaluate the number and type of high-risk situations, the temptation to use in these situations, confidence that one will not use in high-risk situations, substance abuse-related self-efficacy, frequency and effectiveness of coping, and substance-specific effect expectancies. More detailed information on the assessment process in cognitive–behavioral approaches to substance abuse and its treatment is available in a number of sources (Donovan, 1998; Donovan and Marlatt, 1988; Monti et al., 1994; Sobell et al., 1988; and Sobell et al., 1994). For a review of assessment tools that can be used in developing a functional analysis see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* (CSAT, 1999c).

Coping Skills Training

A major component in cognitive–behavioral therapy is the development of appropriate coping skills. Deficits in coping skills among substance abusers may be the result of a number of possible factors (Carroll, 1998). They may have never developed these skills, possibly because the early onset of substance abuse impaired the development of age-sensitive skills. Previously developed coping skills may have been compromised by an increased reliance on substances use as a primary means of coping. Some clients continue to use skills that are appropriate at an earlier age but are no longer appropriate or effective. Others have appropriate coping skills available to them but are inhibited from using them. Whatever the origin of the deficits, a primary goal of CBT is to help the individual develop and employ coping skills that effectively deal with the demands of high-risk situations without having to resort to substances as an alternative response.

A number of published treatment manuals are available to guide skills training with substance users (Carroll, 1998; Kadden et al., 1992; Monti et al., 1989). These manuals provide a session-by-session overview of the intervention. The material covered in these interventions can be categorized into a number of broad classes. The skills to be taught are either specific to substance abuse (e.g., coping with craving, refusing an offer of alcohol or drugs) or apply to more general interpersonal and emotional areas (e.g., communication skills, coping with anger or depression). They are either cognitive or behavioral in nature. Some might be viewed as essential and would be expected to be used for all clients, while others would be viewed as more elective in nature and would be selected for a particular individual based on the functional analysis. The ability to individually tailor the skills training to the client's needs represents one of the strengths of CBT.

Figure 4-19 presents a list of session topics (Monti et al., 1989) which served as the foundation for the CBT delivered in Project MATCH (Matching Alcohol Treatment to Client Heterogeneity Project) (Kadden et al., 1992), a large multisite study of treatment matching funded by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). While the topics used in this particular example were developed for use with clients with alcohol abuse disorders, they are easily adapted to the needs of clients who are abusing other substances.

According to Carroll, teaching coping skills is the core of CBT (i.e., helping clients recognize the high-risk situations in which they are most likely to abuse substances and to develop other, more effective means of coping with them) (Carroll, 1998). The therapist teaches the client specific behavioral skills for forming and maintaining interpersonal relationships. For example, a client may be taught how to refuse a

Figure 4-19
Intrapersonal and Interpersonal Skills Training Elements

Intrapersonal Skills

- Managing thoughts about substance abuse
- Problemsolving
- Decisionmaking
- Relaxation training and stress management
- Becoming aware of anger
- Managing anger
- Becoming aware of negative thinking
- Managing negative thinking
- Increasing pleasant activities
- Planning for emergencies
- Coping with persistent problems

Interpersonal Skills

- Refusing offers to drink or use drugs
- Starting conversations
- Using body language
- Giving and receiving compliments
- Assertiveness training
- Refusing requests
- Communicating emotions
- Communicating in intimate relationships
- Giving criticism
- Receiving criticism
- Receiving criticism about substance abuse
- Enhancing social support networks

Source: Kadden, 1995, adapted from Monti et al., 1989.

drink in a social situation (which might include some form of assertiveness training, as described in Figure 4-20). Learning how to develop new social contacts with people who are not substance abusers is another example.

Skills training sessions follow a relatively standardized format. The client is given an overview of the session, describing the area to be addressed and the rationale for the specific intervention to be used. This is facilitated by skill guidelines that focus attention on the most important aspects of the approach as it applies to substance abuse. After discussing the issues involved in the session, the therapist models the effective coping skill for the particular topic. The therapist then asks the client to participate in a role-playing scenario in which he can rehearse the new coping behaviors. The therapist provides feedback and guidance while the client continues in the behavioral rehearsal. Between sessions, therapists often give homework assignments that provide the client with an opportunity to try behaviors learned in sessions in real-life settings. The next session usually begins with a review of this homework and the client's reactions to it.

Figure 4-20
Assertiveness Training

The client is encouraged to disclose and express emotions and needs, to stand up for his rights, to do what is best for himself, and to express negative emotions constructively. This is useful for clients with substance abuse disorders because being unable to express their emotions and needs may lead to relapse. As a client becomes more assertive, he will be better able to control his impulsive behavior as well as the environmental factors that may lead to relapse. Assertiveness training is usually combined with other psychotherapy because it requires a change in attitude as well as in behavior.

Skills training approaches have been evaluated more than many other approaches to substance abuse disorders. Monti and colleagues evaluated a coping skills training intervention for cocaine-dependent clients (Monti et al., 1997). A cocaine-specific skills training intervention, administered as individual counseling, was added to a more comprehensive treatment program along with a placebo control. The approach involved the identification of high-risk situations based on a functional analysis and the teaching of coping skills to deal with these situations. In comparison to the control condition, clients who received individualized coping skills training had significantly fewer days of cocaine use and significantly shorter periods of binge use of cocaine over a 3-month followup period. Although the two groups did not differ in their rates of relapse, the pattern of use and the harm associated with it clearly favored the skills training condition.

Relapse Prevention

The third core element of CBT is relapse prevention. While there are a number of different models of relapse (Donovan and Chaney, 1985), the two best articulated within the cognitive–behavioral model are those presented by Annis and Davis and Marlatt and Gordon (Annis and Davis, 1988b; Marlatt and Gordon, 1985). Relapse prevention approaches rely heavily on functional analyses, identification of high-risk relapse situations, and coping skills training, but also incorporate additional features. These approaches attempt to deal directly with a number of the cognitions involved in the relapse process and focus on helping the individual gain a more positive self-efficacy.

Although self-efficacy is related to the availability of coping skills and would be expected to increase as the client learns new skills, this does not always occur spontaneously. It is often necessary to help the client change the passivity and sense of helplessness that often accompany low self-efficacy. Bandura noted that there are a number of ways to increase self-efficacy (Bandura, 1977). However, the model that appears to have the greatest impact and lasting influence uses the idea of performance accomplishments to enhance client self-efficacy. In this model, the client is coached to do something that she previously was unable to do. Annis and Davis use graduated homework assignments to help in this process (Annis and Davis, 1988b). The client gradually exposes herself to increasingly difficult situations with greater relapse risk but does so without using. The rate of the exposure is calculated to be at a level that can be handled by the client. The accomplishment of these homework tasks serves as a point of discussion to reinforce the client's growing sense of self-efficacy.

The therapist practicing CBT will also challenge the attributional process and emotional aftermath of a relapse. If a slip occurs, the therapist should try to bring the more negative attributions for relapse (internal, stable, and generalized) to the client's attention so that he can identify these tendencies and learn how to change them. Clients can be helped to see the relapse as caused by a lack of appropriate coping skills for the particular situation (i.e., external), alterable with training or practice (i.e., unstable), and not implying that everything the person does is wrong (i.e., specific). This change in perspective will help reduce the client's sense of helplessness and loss of control. Addressing the attributional process should be done in the broader context of educating the client about the relapse process.

Research has consistently shown that people who expect more positive effects from substances are more likely to abuse them (Brown, 1993; Goldman and Rather, 1993). It has also become clear more recently that individuals who are aware of and concerned

about the more negative consequences associated with substance abuse are less likely to use (Jones and McMahon, 1996). There are also significant differences in the way men and women react to expectancies concerning substances; males are more affected by positive expectancies, whereas the positive expectancies of females are more balanced by negative expectancies (Romach and Sellers, 1998).

The therapist can work to challenge a client's positive expectancies about the effects of substances. There are two strategies that the therapist can use concerning expectancies in order to decrease substance abuse: change the client's belief in the positive effects of the substance or get her to pay more attention to her knowledge and experience of its negative effects.

For a long time, researchers did not believe that positive expectancies concerning substance effects could be changed, but a study on heavy-drinking college students showed that expectations regarding alcohol effects could be altered (Darkes and Goldman, 1993). In group sessions, several techniques were used to make the students aware that some of their alcohol-related expectancies were false. For example, the heavy-drinking college students were told that the beverages they were drinking contained alcohol, but they were actually given nonalcoholic drinks, disguised to look, smell, and even taste like alcohol. They then engaged in group party games, in which most displayed the uninhibited behavior that is associated with alcohol intoxication. Later, when they were told that their beverages were actually placebos, they were surprised. Group discussion and other information on placebo effects altered their perceptions of the positive effects of alcohol. A significant decrease in alcohol consumption was noted in this group after the intervention, compared to a control group that received conventional information on the effects of alcohol. Challenging social beliefs about the effects of a substance may alter its use.

Another way to use substance expectancy information in therapy is to have the client consider both the positive and negative effects of the substance. Many clients have automatic scripts like "I'll feel more relaxed if I drink" without considering other scenarios, like: "I'll drink too much. I'll have a fight with my girlfriend, and then I'll sleep in and not go to class." The therapist helps the client acknowledge that the other consequences exist and are not being attended to. It is possible to use a decisional balance procedure in this process, wherein the client is asked to list all the positive and negative things associated with drug use. By acknowledging the substance's positive effects, the therapist gains credibility and reduces resistance from the client. The client can more easily acknowledge the negative aspects of substance abuse and make those beliefs more salient. This technique is a mainstay of motivation enhancement therapies that are largely cognitive in nature (Miller and Rollnick, 1991). (TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c], gives more detailed information on these approaches.)

Relapse prevention also stresses the importance of preparing for the possibility of a relapse and planning ways to avoid it or, failing this, stop the process quickly and with minimal harm when it does occur. Clients are sometimes apprehensive about talking so directly about the possibility of relapse. The therapist can help dispel these concerns by using an analogy of fire drills. Having a drill and being prepared for a fire does not necessarily mean that a fire will occur. However, if one does, it will be possible to get out of the situation without getting burned. It is helpful to have very concrete emergency plans, including the phone numbers of individuals supportive of the client's recovery

process. Including family members in the planning process is important because they are often better able than the client to see the warning signs of an impending relapse.

Relapse prevention also stresses the development of a more balanced and healthier lifestyle. Marlatt and Gordon posit that one source of possible relapse risk has to do with the degree of stress or daily hassles that the client experiences (Marlatt and Gordon, 1985). They suggest that when the demands and obligations a client feels ("shoulds") outweigh the pleasures the individual can engage in ("wants"), then his life is out of balance. This often results in feelings of deprivation and resentment. In response to these feelings, the individual could begin making decisions that gradually lead toward possible relapse. The goal is to help the individual find a better balance, increasing involvement in pleasant and rewarding activities while reducing the level and sources of stress.

A Case Study Using CBT

The following case study involves a young male cocaine user who has sought outpatient treatment. It reflects interactions early in the course of the session and is meant to depict some of the questions the therapist could ask to gain information about the antecedents, consequences, and cognitive mediators involved in his use.

Therapist: *So, can you tell me about your cocaine use and why you are coming to treatment now?*

Client: *Well, I finally came to the end of my rope. I kept using even though I didn't want to, and I felt that I was nothing but a junkie who had no future. It's just hopeless.*

Therapist: *What makes you say that?*

Client: *Well, I just can't stop using. Even when I've gone through treatment in the past, I end up using in no time. When I look at my track record, I don't see much of a future.*

Therapist: *I wouldn't give up hope yet. We'll work together to help you get a better look at your cocaine use, some of the things that trigger it, and some of the benefits you think you get from it. Sometimes by looking at your use from a different perspective, you can help put it into context and things don't seem so hopeless. Now why don't you tell me about how you slipped and started using after your last time in treatment. What was going on in your life? What were you feeling? What were you thinking about yourself and your life?*

Client: *Well, when I got out I still had some doubts about whether I would make it or not. I mean I felt better about myself, but there was still a lot of crap going on in my life. I had bills to pay. My relationship was falling apart. I was still being hassled by my probation officer. I was feeling kind of overwhelmed. Here I thought I would walk out of there a new man, but I walked out with all the same problems.*

Therapist: *Was there any time after treatment when you felt you could handle all the problems facing you?*

Client: *Well, for a while, then I started to feel depressed. I mean you go through treatment, and this stuff shouldn't be happening.*

Therapist: *What did you try to do to deal with it all?*

Client: *At first I thought I would get myself organized and get a plan. But it didn't work. As much as I tried, I couldn't figure out a way to put all this stuff in its place and handle it. So I just threw up my hands and said, "Screw it!" I felt like the best thing to do was to pull*

the blankets over my head and hope that it would all blow over.

Therapist: *So, did it blow over?*

Client: *No. Things just kept getting worse. I couldn't pay my bills. My relationship was gone, and I got booted out of my apartment.*

Therapist: *As all this was happening, did you think about using cocaine?*

Client: *You bet I did! I kept thinking, "Damn, it sure would feel good to get all this off my mind." And I knew that if I used coke it would all go away—at least for a while.*

Therapist: *So, as you thought about the cocaine, what positive things did you think you would feel if you used?*

Client: *I knew I'd feel a rush, I'd feel damn good—and I'd just forget. I could get out of the depression and funk I'd been in. I was just looking to feel better.*

Therapist: *Did you think of any negative things about using?*

Client: *Yeah. I always seem to crash after using. So I lose the high and find myself sometimes even more depressed than before. But that didn't seem to bother me. I'm willing to put up with it for a while. I'll take the high any day. It lets me get away from all this crap—at least for a while.*

Therapist: *So what were the circumstances of your starting to use again?*

Client: *Well, like I said, I got booted from my apartment. And I couldn't go stay with my girlfriend since she booted me too. So I had to find a place to stay. I called an old friend who said I could stay at his place for a while. We used to do a lot of drugs together. I knew he might not be the best person to be staying with, but he was the only one I felt would put up with me. So, I moved in. I was feeling pretty low, thinking about everything that had happened to me and was not sure what I was going to do. My friend pulled out some coke and asked if I'd like some. I just kept thinking of how lousy I felt and how good I would feel if I used. So I said yeah, why not.*

In this case study, it is clear that the client has a low sense of self-efficacy predicated in part by his past treatment failures and his inability to cope with difficult situations. As a result, he feels depressed and helpless. He makes a half-hearted attempt at problemsolving but fails in this attempt. Then he switches to passive-avoidant approaches in order to cope (e.g., pulling the blanket over his head and hoping it will all blow away). His depression continues unabated as the daily hassles mount. The positive expectancies he has about cocaine as the "magic elixir" are quite strong and seem to outweigh potential negative consequences. His situational context contains two high-risk situations. The first is the negative mood states that he experiences, when he has abused substances in the past. The second is the indirect social pressure involved in returning to a setting that had been associated with substance abuse in his past. There is also the proximal influence of the direct social pressure to use from his friend. The likelihood of relapse was high, and, in fact, relapse occurred.

The therapist in this case might consider using skills training that focuses on problemsolving, stress management to alleviate his depression, developing communication skills, practicing substance refusal skills, and developing a social support network. The therapist should target both this client's low self-efficacy and his positive cocaine-effect expectancies. Clearly the full intervention plan would require further assessment and a functional analysis; however, a direction for further treatment can already be seen in this brief interchange.

Duration of Therapy and Frequency of Sessions

Two advantages of CBT are that it is relatively brief in duration and quite flexible in implementation. CBT typically has been offered in 12 to 16 sessions, usually over 12 weeks (Carroll, 1998). The form of CBT used in NIAAA's Project MATCH (Kadden et al., 1992) consisted of 12 sessions, administered as individual therapy, meeting once per week. The sessions included eight "core" sessions that dealt with alcohol-related issues (e.g., coping with craving, drink refusal, relapse emergency planning) and general problem-solving skills that all clients were expected to receive, and four "elective" topic areas chosen from a menu of more general social and interpersonal issues based on individually assessed problem areas. A 12-session CBT for cocaine addicts suggested that this length of treatment is sufficient to achieve and stabilize abstinence from cocaine (Carroll, 1998). However, not all clients will respond in that amount of time. In such cases, an initial trial CBT can serve as preparatory to a more intensive treatment experience.

When To Use Cognitive–Behavioral Therapy

Varieties of cognitive–behavioral therapy are applicable to a wide range of substance abusers. The outpatient CBT program developed by Carroll for cocaine users excluded a number of different clients as inappropriate for that form of treatment (see Figure 4-21). However, even though these criteria were derived from cocaine users, they appear to be applicable to clients using other substances.

While reliance on the results of the functional analysis makes skills training particularly well suited for individual therapy, these interventions can easily be adapted for use in group settings (Monti et al., 1989). Similarly, they can be used with inpatients or outpatients and can be administered as part of an intensive phase of treatment or as part of less intensive aftercare or continuing care. CBT is also compatible with a number of other elements in treatment and recovery, ranging from involvement in self-help groups to pharmacotherapy (Carroll, 1998).

Efficacy for Treating Substance Abuse Disorders

In contrast to many other therapies, cognitive–behavioral therapy for the treatment of substance abuse disorders has substantial research evidence in support of its effectiveness.

The research findings on the use of coping skills training with alcohol- and cocaine-dependent clients indicate that this strategy has strong empirical support. A review of outcome studies evaluating the efficacy of relapse prevention interventions indicates that the support for relapse prevention is more equivocal (Carroll, 1996b). Relapse prevention was found to be superior to no treatment, but the results have been less consistent when it is compared to various control conditions or to other active

Figure 4-21

Types of Clients for Whom Outpatient CBT Is Generally Not Appropriate

- Those who have psychotic or bipolar disorders and are not stabilized on medication
- Those who have no stable living arrangements
- Those who are not medically stable (as assessed by a pretreatment physical examination)
- Those who have concurrent substance dependence disorders, with the possible exception of alcohol or marijuana dependence

Source: Carroll, 1998.

treatments. There are some outcomes on which relapse prevention may have considerable impact (Carroll, 1996b); for instance, although not necessarily reducing the rate of relapse, clients treated in relapse prevention appear to have less severe relapses when they occur.

Overall, behavioral, cognitive, and cognitive-behavioral interventions are effective, can be used with a wide range of substance abusers, and can be conducted within the timeframe of brief therapies.

5 Brief Strategic/Interactional Therapies

Strategic/interactional therapies attempt to identify the client's strengths and actively create personal and environmental situations where success can be achieved. In these therapies, the focus is on the individual's strengths rather than on pathology, the relationship to the therapist is essential, and interventions are based on client self-determination with the community serving as a resource rather than an obstacle. This model has been widely used and successfully tested on persons with serious and persistent mental illnesses (Rapp and Wintersteen, 1989; Saleebey, 1996; Solomon, 1992). It has also been used with persons who have problems related to substance abuse (Juhnke and Coker, 1997; Miller and Berg, 1991; Ratner and Yandoli, 1996; Watzlawick et al., 1967). Although the research to date on these therapies (using nonexperimental designs) has not focused exclusively on substance abuse disorders, the use of these therapies in treating substance abuse disorders is growing.

Many different theoretical approaches have strategic or interactional roots. They can be distinguished from each other primarily by the different emphasis and value they place on components of the change process. Therapists rarely follow a single theoretical approach strictly; therapists today influence and learn from each other, incorporating what they find useful into their own work.

All of these models stem in part from the work of Milton Erikson. He coined the term *strategic therapy* to describe an approach in which the therapist takes responsibility for finding new and effective strategies to help clients in distress. Jay Haley, John Weakland, and other theorists of the Mental Research Institute (MRI) consulted with Erikson as they expanded on his theoretical approach.

More recently, Steve De Shazer and his colleagues, who were influenced by the MRI approach, shifted the focus of treatment from problems to solutions, calling their modality *solution-focused therapy*. Their approach, originally developed to work in brief marriage and family therapy, has since been used in a variety of situations for a variety of presenting problems, including substance abuse disorders. (See Chapter 8 for more information on the application of all these therapies to the treatment of families.)

Interactional therapy is based on the assumption that problems can best be understood by examining clients' (often dysfunctional) interactions with others and their resulting problems. Strategic therapy is a form of interactional therapy because it does not focus on the root causes of the client's problems but instead tries to increase competency and develop problem-solving skills that will help the client in her interactions with others. For the

purpose of this discussion, however, the combined term *strategic/interactional therapy* is used. This broader term allows solution-focused therapy, which is certainly interactional, to be included in this section. Although it has a strong kinship with strategic approaches, not all practitioners consider solution-focused therapy to be "strategic."

The significance of these different approaches can be found in their presentation of an alternative approach to understanding how substance abuse disorders evolve and how new innovative solutions could be generated to assist with the resolution of these problems.

The Consensus Panel believes that these therapeutic approaches are potentially useful for clients with substance abuse disorders and should be introduced to offer new knowledge and techniques for treatment providers to consider. This chapter presents one strategic/interactional approach, solution-focused therapy, which has been used in substance abuse treatment. Information on when to use solution-focused brief therapy with substance abuse clients, a case study using strategic/interactional approaches with a substance-abusing client, and the general theories that provide the basis for strategic/interactional therapies are discussed below.

Solution-Focused Therapy for Substance Abuse

While this chapter covers several strategic and interactional theories and practices, most of the work currently being done on substance abuse treatment uses a solution-focused approach. Solution-focused therapy is always brief, and to date there has not been a great deal of research comparing it to other models.

Research by Iguchi and colleagues supports some of the theoretical claims made by solution-focused therapists (Iguchi et al., 1997). The solution-focused therapist believes that helping clients with substance abuse disorders to address any life problems they find significant will help them to reduce their substance use. What is important is finding a solution to the problems the client identifies as significant, then reinforcing the client's success in solving those problems. This procedure helps the client to recognize her own ability to solve her problems. The study by Iguchi and colleagues compared the role of urine testing, traditional substance abuse counseling services, and the reinforcement of nonsubstance–use-related positive life changes and found that the latter resulted in the most significant reduction in substance use even after reinforcement contingencies ended.

The solution-focused therapy model has been used to respond to a range of problems and complaints. Researchers Berg and Miller were the first to apply the model specifically to the treatment of alcohol-related problems, but others also have used these techniques for treating substance abuse disorders (Berg, 1995; Berg and Miller, 1992; Berg and Reuss, 1998; Ratner and Yandoli, 1996). This treatment model is not necessarily a useful treatment strategy for all clients with substance abuse disorders; no one model is. However, this model is a "complex and varied package of strategies that can be applied in an individualized, eclectic fashion to those seeking treatment" for a multifaceted and complex problem (Berg and Miller, 1992, p. xix). Berg and Reuss delve into greater detail regarding the applications of solution-focused brief therapy to the treatmenf of substance abuse disorders (Berg and Reuss, 1998).

One technique of solution-focused therapy is to focus on the exceptions to the client's problems. For example, in providing solution-focused brief therapy for a client with a substance abuse disorder, the therapist should

direct the client's attention to periods when he was substance free. To identify these periods, the therapist must listen carefully to the client's responses, then ask the client to discuss those periods. The purpose is to help the client realize that he can maintain sobriety and has, in fact, done so in the past. The idea of focusing on the exception to any presenting problem is an aspect of strategic therapy that has particular relevance to the substance abuser because, as Berg notes, almost every substance abuser has had some period of abstinence—in many cases this period may have lasted months or years (Berg, 1995).

Exceptions to presenting problems may fall into two categories, *deliberate exceptions* and *random exceptions* (see Figure 5-1 for definitions). The more deliberate the behavior on the part of the client, the easier it will be for her to repeat it. But even substance-free periods that seemed to result from outside influences (i.e., random exceptions) can be used to help the client realize her own ability to stay sober.

As discussed above, a therapist using a solution-focused approach works closely with the client to understand the client's own perspective on her problems. By focusing on those areas the client considers significant (e.g., relationships, work, financial security), the therapist assists the client in understanding how her substance abuse affects those significant areas of concern. The therapist helps the client solve those significant problems while strongly reinforcing the client's success. After the initial session, the therapist keeps the client focused on how her situation is improving by asking, "What's better this time?"

Compatibility of Strategic/Interactional Therapies and 12-Step Programs

Strategic/interactional approaches can be used in conjunction with other treatments, even those that require a longer term commitment. Strategic/interactional therapies are guided by an intent to generate a unique set of techniques, approaches, or modalities that are effective for a particular client. For some clients, a combination of brief therapy with longer term participation in another treatment program, such as a self-help group, will be most effective.

In spite of some theoretical differences, strategic/interactional approaches can be used successfully in conjunction with 12-Step programs. These approaches, especially identifying triggers that can lead to relapse or

Figure 5-1

Deliberate and Random Exceptions to Substance Abuse Behaviors

Deliberate exceptions are situations in which a client has intentionally maintained a period of sobriety or reduced use for whatever reason. For example, a client who did not use substances for a month in order to pass a drug test for a new job has made a deliberate exception to his typical pattern of daily substance use. If he is reminded that he did do this in the past it will demonstrate that he can repeat the behavior.

Random exceptions are occasions when a client reduces use or abstains because of circumstances that are apparently beyond her control. The client may say, for example, that she was just "feeling good" and did not feel the urge to use at a particular time but cannot point to any intentional behaviors on her part that enabled her to stay sober. This type of exception is more difficult for the therapist to work with but can also be used to help the client perceive her own efficacy. In such instances the therapist can ask the client to try to predict when such a period of "feeling good" might occur again, which will force her to begin thinking about the behaviors that may have had an effect on creating the random exception.

exploring barriers that can prevent the client from going to Alcoholics Anonymous (AA) meetings or calling his sponsor, can be applied to critical points in maintaining sobriety. For example, the therapist can help the client identify the "payoff" for not attending the meeting and the key players in the system that maintains the client's substance abuse. Even a client who feels he is powerless over substance abuse without the help of a higher power can recognize he has some control over the choices that lead to substance abuse.

Some therapists familiar with 12-Step programs may be concerned that the strategic/interactional approach is opposed to viewing addiction as a disease. The focus on empowering the client may seem incompatible with the first step (i.e., "we admitted we were powerless over..."). However, the key to therapeutic success with this approach is the ability to work within a client's frame of reference. Therapists can acknowledge that addiction is a disease but still use the strategic/interactional approach to enhance clients' coping skills and help them to control the use-related behaviors that clients may believe are random and spontaneous. Strategic therapists who do not accept a disease model may tell a client, "You have a disorder of the pleasure centers in your brain," and work with the client to find healthier ways to activate those "pleasure centers."

When To Use Strategic/ Interactional Therapies

No matter which type of strategic/interactional therapy is used, this approach can help to

- Define the situations that contribute to substance abuse in terms meaningful to the client
- Identify steps needed to control or end substance use
- Heal the family system so it can better support change
- Maintain behaviors that will help control substance use
- Respond to situations in which the client has returned to substance use after a period of abstinence

More specifically, strategic/interactional approaches are useful in

- Learning how the client's relationships deter or contribute to substance abuse
- Shifting power relationships
- Addressing fears

Most strategic/interactional therapies ask a client to consider the question, "How do you understand your using?" (Solution-focused therapy is an exception because it concentrates instead on improving the situation.) Often, as the therapist and client explore the client's understanding of the abuse, critical relationship issues surface—even when the client appears to be isolated from family and friends. Even if a client seems to have no existing family connections, the family sometimes plays a role in her substance abuse. Her family, or her reaction to it, may have influenced her decision to begin using or her decision to stop. Messages from the family (internalized or actual) can also play an ongoing role in the client's choice to continue using.

One therapist treated a woman whose entire family appeared to have alcohol-related problems and who believed that everyone drank, but at different levels. For this client, a strategic/interactional approach helped her become aware of new possibilities, develop social skills, and identify sober activities. She learned to see the world as a richer place with many options. The therapist in this case chose to be directive and showed the client the possibilities for change that exist. To many clients who are trying to change their behavior, it is reassuring to believe that "there is someone

who knows the way." The therapist using this strategic/interactional approach should convey a sense of hope that bridges the chasm between what is and what could be and support the client through the change process with respect.

The strategic/interactional approach can also help break through a stalemate in a relationship that blocks healing, particularly if there has been a power struggle that has left both parties exhausted and with an apparently restricted range of options. In a power struggle, each person says she is right and the other is wrong; one of them must give in. When the strategic/interactional approach is applied to power struggles it can help to "open up the system," working to change the clients' perceptions of each other and their relationship and enable them to see a broad range of options. Both parties are assisted in seeing themselves as strong, capable, and in control. Because the substance abuser typically feels helpless, inadequate, and condescended toward, the therapist often has to rebalance the power structure to promote more effective interactions.

For example, in a situation where one partner pushes the other to stop drinking, the partner who has been drinking may feel controlled and demeaned and therefore may withdraw in a passive manner or react with an explosive temper. He then gets drunk to further express his anger or to get even. The partners' respective behaviors maintain the problem. The therapist works to help each partner perceive the other more positively. As this is accomplished, each person becomes more receptive to new solutions. The therapist then helps the partners identify specific changes they can make, thus dismantling the old system and laying the foundation for a new one that can support different behavioral choices.

The strategic/interactional approach is also an appropriate way to address a client's fear of change. Often, clients feel that "something worse" may happen when they quit using. In the Eriksonian model, a therapist might ask the client to project herself into the future and describe what it will be like when the changes just discussed have been made, or talk about a "future self" who has resolved current problems and for whom current fears are no longer an issue. Such strategies are useful in confronting common fears and helping clients see beyond them.

Duration of Therapy and Frequency of Sessions

Most forms of strategic/interactional therapies are brief by the definition used in this TIP. Strategic/interactional therapies normally require 6 to 10 sessions, with 6 considered typical. Sessions are usually weekly, and it is not advisable to have more than two sessions per week. This type of therapy often involves assigning "homework" for the client to observe how specific changes in behavior affect the problem, and time is needed to determine how a new strategy is working and see how the system is affected by the change.

In solution-focused brief therapy, the client is encouraged to determine the length of time needed between sessions. This approach helps the client take ownership of the process and recognize his power to control change (realizing that one has the power to choose often is the solution itself).

Applicability to Different Types of Clients

In strategic/interactional approaches, clients are traditionally defined as customers, complainers, or visitors. Customers are clients who state that they have a problem, they can not cope with the problem on their own, and they need the therapist's help. Strategic/interactional approaches are particularly helpful for the latter two types of clients—those who think someone else should change to resolve the presenting problem (complainers) and those who see their

presence in treatment as involuntary (visitors). Strategic/interactional therapies offer these kinds of clients a way to make effective changes within their own frames of reference.

For example, consider a client who feels her boss overreacted to her substance abuse and believes she should not have been forced to enter treatment to retain her job. Instead of working to try to convince the client she really does have a problem, the therapist can make progress working within her view of the situation, perhaps by saying, "So your boss thinks you have a problem. What would it take to get him off your back?" The assumption that the client wants to be free of the problems caused by this other person gives the therapist something to focus on without challenging the client's view of the situation.

Most clients with substance abuse disorders can be viewed as "hidden customers" who desire some sort of change in their behavior, even if they are not willing to articulate that fact (Berg, 1995). Given that, the therapist's task is to make the "complainer" or "visitor" aware that he is in fact a "customer" of the therapist's services.

When Might a Strategic/Interactional Approach *Not* Be the Best?

Eriksonian approaches may be contraindicated for clients with severe disorders. Clients who have personality disorders (Axis II) may jump quickly from one suggestion to another without a clear sense of how to make use of therapeutic suggestions. Because they feel a need to stay in therapy they may resist solutions that would bring an end (albeit a successful one) to their relationship with the therapist. Clients with impaired brain function as a result of substance abuse may not be good candidates for this approach either. (For these clients, a more directive approach is helpful.) However, even when it is difficult to use this approach directly with the client, it may still be an effective modality to use with family members to help them change behaviors that support the client's substance abuse (Fisch et al., 1982).

For other populations, the approach may have to be adapted to work effectively. The therapist may have to use supportive props such as handouts of the agreed-upon plan of action and a list of goals to help keep the client on track. Strategic/interactional strategies can be simplified for people who have a cognitive impairment. Because this approach works with the client's language and functional level, a client with a cognitive disability may be able to identify and meet goals appropriate to her skills and abilities. Many therapists believe that the solution-focused approach is useful with clients who have schizophrenia, and research supports its effectiveness with some clients who have serious mental illnesses (Saleebey, 1996; Solomon, 1992).

Case Study

Figure 5-2 presents a portion of a dialog between a counselor and a client, a 45-year-old real estate agent who was treated 4 years ago in an inpatient treatment program and thereafter attended a 12-Step group to help him stop his polysubstance abuse (cocaine and alcohol). After experiencing 3 clean and sober years, he began to use again. The client started gambling, then using cocaine and alcohol while gambling. His real estate license is now in jeopardy because of customer complaints and reports to the State Licensing Board. He was recently convicted for a second time for driving under the influence (DUI), and his wife and family moved out. The client tells the therapist that his renewed abuse of substances was the result of the gambling. Unlike the negative feedback from family, colleagues, and other professionals,

Figure 5-2
Strategic/Interactional Therapy in Practice: A Case Study

Conversation	***Observations***
Client: Things were going great. I was going to a lot of meetings. I felt life was getting better. I was getting along with my kids. Getting in touch with the spiritual part of the problem. I don't know what happened.	
Therapist: What led you to go gambling?	
Client: I guess I'd been gambling for a few months before I got high. I was bored.	*The first trigger (boredom) has been identified; this will have to be reframed as treatment progresses.*
Therapist: What is the experience of gambling like?	
Client: I really feel alive.	
Therapist: When did you first use again?	
Client: I spent too much money on gambling, and my wife yelled at me the same way she used to when I got high on cocaine. I won a whole lot, really. It wasn't fair.	*An important interactional element surfaces. Sometimes the things that spouses or significant others do or say can either reinforce the client's substance abuse or help him out of the problem.*
Therapist: What do you do when your wife gets angry at you for spending money?	
Client: I just say, "Yeah, you're right." And then I go away. Then she hassles me some more. There are times I blow up, but normally I just try to let it go by.	
Therapist: Sounds like when you were gambling, you were excited. So I don't get it—what went wrong? Why did you need the cocaine, too? Is it possible gambling wasn't enough?	*Nonjudgmental language is used to enter the client's frame of reference/world-view. It is best if the client is able to define the substance abuse as a problem he wants to overcome rather than have the therapist define this for the client.*
Client: I guess I just needed more of the high, you know. My wife and I were fighting more. The pressure was getting to me. I guess that's when I started on the cocaine.	
Therapist: How did that cocaine work for you?	

Figure 5-2 (continued)
Strategic/Interactional Therapy in Practice: A Case Study

Conversation	*Observations*
Client: I was excited. I felt really powerful.	
Therapist: What went wrong? What led you start using alcohol, too?	
Client: I got scared. I was up for 3 days. The alcohol helped me come down and sleep.	*Here the therapist gets some understanding of the sequence of the client's substance abuse.*
Therapist: Sounds scary to me. How did you get through that scared period? You tolerated it somehow for 3 days.	*The therapist validates the client's experience, rather than criticizing the client's behavior.*
Client: It was kind of a blank, mostly. I felt I had to fix it somehow. That's when I started drinking.	
Therapist: How did you know alcohol would work?	
Client: I've used it to bring me down before.	
Therapist: I hear that you realized something needed to be done, and you knew you needed something to slow you down, and you took action.	*The therapist is pointing out that the client's action was an attempt at regulation, though not a long-term solution. The statement reminds the client that he is in control and making choices. It reaffirms the client's strength and coping skills—the client made an adaptive response to a difficult situation and may make a different choice next time.*
Therapist: So how is this a problem for you now?	*This question brings the client back to defining the problem for himself, rather than letting the therapist or someone else (spouse, boss, probation officer, etc.) define it for him.*
Client: Well, I lost my family, almost lost my business, and I'm facing another DUI.	*This "hopeless and helpless" stance should be shifted. Solution-focused and MRI approaches would try to promote effective strategies and eliminate ineffective ones. An Eriksonian might challenge the client to compare his positive and negative self-image (i.e., the way it feels to go to AA and stay sober versus how it feels after getting high).*

Figure 5-2 (continued)
Strategic/Interactional Therapy in Practice: A Case Study

Conversation	***Observations***
Therapist: So where do you want to go now? Why are you here?	*This therapist is using a strategic approach to shift the client off helplessness to a self-motivational statement: "I really need to change my life."*
Client: I want to get sober again. I went back to AA, but now I can't stay sober more than a day.	
Therapist: When you were determined to stay sober, you were successful. What's different about the way you're trying to do this now?	
Client: Well, now, I'll leave the meeting and go get high.	
Therapist: And how is that working for you?	
Client: It's not working! I just start feeling worse about myself. I've been through so much already. I really just need to stop.	
Therapist: It sounds to me like you have incredible inner strength. What keeps you going?	*Here is a "make it or break it" point in treatment. The therapist is seeking a key that will move the client to action (e.g., his love of his children, his desire to get his wife back, his concern about his job). In this case, the therapist has just learned that the client fears he will die as a result of his use.*
Client: I don't want to die.	
Therapist: It sounds like you have a very strong, competent side that wants the best for you and wants to live. Let's use that competent part of you to get back on track and rebuild your life. What do you think?	*Some therapists would call the competent self the "recovery self."*
Client: I would like that.	
Therapist: Let's begin by figuring out where you are now. On a scale of 1 to 10, on which "1" is the worst you could feel and "10" is "clean, sober, and successful," where are you now?	*The "readiness ruler" is an effective way to determine the client's readiness to change and identify next steps. The therapist is using this technique to identify a baseline to measure progress and focus the client in the direction of change and progress.*

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Figure 5-2 (continued)
Strategic/Interactional Therapy in Practice: A Case Study

Conversation	Observations
Client: Well, now I feel like an "8," but I know it's temporary. When I go back home, I'll probably get back to a "2" right away.	
Therapist: That's good because slow change is more important than fast change. You really can't count on fast change to last. So if you did slip back to a "2," what would it take to move you to a "3"?	*At this point, the therapist is ready to define some kind of action and seek commitment to change. The response is also intended to encourage the client by identifying small, feasible steps*
Client: I guess more of what I know works or what used to work, anyway. Going to meetings or calling my sponsor. That kind of thing.	
Therapist: Sounds good. You said now you go to AA meetings and get high afterward. What did you do afterwards when you didn't do that, when you stayed sober?	*The therapist is looking for exceptions: times when something the client did worked and he experienced success.*
Client: Went home. Watched TV. Had fun with my wife; sometimes we made love. Now that she's not there, I really dread the evenings. They are so empty. I just go back and stare at the ceiling.	
Therapist: So when you don't have things to do, you get antsy.	*The therapist is reframing the problem to open the door to a solution.*
Client: Yeah. I guess so. I get lonesome.	
Therapist: Yes, it is difficult to go home to an empty place. But it sounds like you have not given up on people. People are still important to you. You want human contact—to care about people and have them care about you.	*The therapist is acknowledging the difficulty, but also pointing out the positive direction implicit in the client's statement. The therapist empathizes with the client, validating his experiences and feelings, but also pointing out the positive direction implicit in the client's statement.*
Client: If nobody's around, I feel empty. I get bored. Then I want to use. I want to make something happen.	

Figure 3-2 (continued)
Strategic/Interactional Therapy in Practice: A Case Study

Conversation	Observations
Therapist: Are you bored now? *Client:* Sort of. Not really here all the way, you know what I mean? Sort of empty.	*This question gives the therapist information on how the client feels and acts when bored and can help the therapist recognize signals of boredom in the future. Sometimes the therapist will have great participation, and the client will still describe himself as bored. It is also important to ascertain whether the boredom results from depression or a sense of emptiness. A better understanding of what "bored" means will enable the therapist to help the client figure out "what's different" and find a solution.*
Therapist: That's interesting. Despite the fact that you feel empty, you can still function. I think there is something internally powerful in you that has not come out. For some reason, it has been suppressed. My guess is that the boredom comes when you suppress that side of you.	*The therapist is framing the client's self-image positively, suggesting a change in the way the client now sees himself.*
Client: You keep talking about this powerful side. I don't get it. I lost everything. Where's this great power I'm supposed to have? *Therapist:* I think it's right here—let's see if we can bring it out a bit. Tell me about a time when you felt tremendous pleasure and control, but you were sober. *Client:* Well, I have to go pretty far back. When I was ten, though, I remember playing baseball and hitting this home run. I really hit that ball.	*A natural response from a client who is mostly focusing on negative perceptions and experiences. The therapist's focus continues to be on shifting the client's perception to positive strengths and constructive action.*
Therapist: Some time this week if you're willing to try something, and only if you're willing, try to bring back that experience. Take note of what it was like and how difficult it was to get there. *Client:* Okay. Maybe I'll try that.	*At this point, the therapist might encourage the client to feel that vibration and run across the bases in his mind or ask whether the activity mentioned is one the client could do in his present life. The therapist could suggest here that a local recreation center, or another way of being physically active, would be an option for restoring the sense of power and control as well as connecting with people.*

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Figure 5-2 (continued)
Strategic/Interactional Therapy in Practice: A Case Study

Therapist: I'm sure there have been a number of things in your life that you've done right, otherwise you wouldn't have survived all of the difficulties you've had. It would help if you could think about those successful or effective behaviors.	*The therapist should make the client work here. If the client is blank, he could be asked to free associate. In a group setting, others could give suggestions.*
Client: I can try.	
Therapist: Now that we've identified that you have all this strength inside of you—and you still do—how do we use it?	
Client: I guess if I could go to AA and stay sober when I get home, that would at least be a start.	
Therapist: What do you think is going to happen at AA?	
Client: It's going to be good to sit there and know I'm not hiding.	*Part of what's happening is that the external and internal pressure resulting from the shame is being reduced; consequently, the feeling about going is changing.*

the therapist, using strategic/interactional approaches, praises the client for coming back to treatment: "Look at what you have done! You're in this chair instead of still out there." The therapist assures the client that relapse is part of the recovery process and suggests that the experience can be seen as educational. In contrast to emphasizing the client's failure, the therapist sends the message, "You're a survivor, not a victim." The therapist affirms the client's ability to stay sober and begins to seek ways to emphasize and draw on the client's strengths. The therapist seeks to understand the events that led up to renewed use but also searches for the behaviors that previously helped the client stay abstinent for 3 years.

This case study is an example of how a brief strategic/interactional therapist might work with a client who has previously been successful at controlling his substance abuse problem but has relapsed. The approach described is a generic strategic/interactional approach and does not represent a pure model of any one type of strategic/interactional therapy. Because the client has relapsed, an important guiding principal is to discover what has caused him to deviate from those behaviors, thoughts, and activities that had previously been effective in controlling his substance abuse. The therapist must then assist the client either to return to those things that have been working before or to add or replace them with strategies that are more effective.

Strategic/Interactional Therapies

The primary strength of strategic/interactional approaches is that they shift the focus from the client's weaknesses to the client's strengths. The therapist's task is to help the client identify, recognize, and use these strengths to make the changes the client sees as beneficial.

Strategic/interactional therapies are based on three primary theoretical assumptions:

1. These therapies take a *constructivist* view of reality. They assert that reality is determined by individual perceptions, which are influenced by cultural, sociopolitical, and psychological factors.
2. These therapies stress the importance of attribution of meaning. According to this theoretical approach, it is the meaning we attribute to situations that determines whether a problem exists. In this model, an important therapeutic goal is to understand the meanings that clients attribute to events—often referred to as the client's "frame of reference"—and to use this knowledge to promote constructive change. This can involve helping clients to construct a different meaning that is more useful to them in the recovery process.
3. These therapies focus on human interactions and the problems that evolve from ineffective ways of coping with situations. There is always some element of social interaction in the development, maintenance, and change process for any problem. By taking these interactions into account, the therapist can better support the client through the change process.

A basic tenet of this approach is the assertion that human problems can be understood by applying the principles of human systems. Problems do not exist in a vacuum; they exist because of relationships with others. The strategic therapist believes that a positive change to one part of a system will positively affect the rest of the system. This approach is distinct from a structural view of systems, however; whereas the structuralist sees the need to consider and try to change dysfunctional aspects of the larger family structure, the strategic therapist does not necessarily posit a systemwide dysfunction—only the existence of *ineffective interactions* within the system.

A strategic approach accepts the fact that clients may not always provide accurate information about the real nature of their problems. It is possible to work with the client's view of what is happening and make progress, even if that view is only partially "correct." For example, consider a client who enters therapy complaining, "My boss drives me to drink." In a cognitive or confrontational approach, the therapist might strive to change this way of looking at reality. The therapist using a form of strategic/interactional therapy might say that this approach represents the client's view of the world and, rather than correcting or altering it in some way, the therapist can make more progress by working within that frame of reference to accomplish strategic objectives. The therapist might ask, "If your boss is driving you to drink, how does that happen and what can you do about that?" The therapist implies that the client must be more effective in interactions with his boss, and this becomes a treatment issue. By working within the client's frame of reference, the therapist can define what the client might do to change key interactions that contribute to substance abuse, *without* buying into the premise that it is only his boss' behavior that must change.

Initial Session

The first question that a therapist using a strategic/interactional approach should ask is, "Why are you here?" The first session should be spent trying to understand the client's problem.

However, different models (discussed later in this section) use different tactics to explore the nature of the problem, as follows:

- The therapist using *Eriksonian therapy* seeks to define the client's problem in the client's terms and probe the way she understands the problem (i.e., the "frame"). Compared to other strategic interactional models, the Eriksonian approach moves more quickly to action, seeks to effect change more quickly, and places greater emphasis on the unconscious processes underlying change.
- The therapist using *solution-focused brief therapy* spends most of the first session defining goals. Throughout the session, the word "problem" is avoided.
- The therapist using the *MRI model* seeks to define the problem in the client's terms and understand the "frame" in a manner similar to the Eriksonian approach. However, this modality focuses on modifying ineffective solutions that have been previously attempted.
- The therapist using *Haley's problem-solving therapy* pays special attention to gaining an understanding of power issues in relationship to the problem (e.g., who controls key decisions).

Later Sessions

Once the therapist has encouraged a person with a substance abuse disorder to take further steps toward change, the subsequent sessions will focus on identifying and supporting additional steps in the same direction. The following are examples of techniques that might be used in the remaining sessions with the client in this case study.

- Set up a termination point. The therapist could ask the client to describe the signs that things are getting better for him, or ask, "What things will you be doing differently?"
- The therapist could continue to develop effective strategies and increase their use. She could use affirmations, continue to use scaling questions, and "join" with the client by acknowledging how difficult it is to change and rebuild his life.
- The therapist should also be aware of the client's motivation to change and continue to ask the client what he thinks will happen if changes take place. This technique demonstrates respect for the client's values.
- The therapist could continue to gather information about the stressors that trigger the client's substance abuse and help him to determine how he can handle them differently. The therapist should ask the client about ways he has successfully handled stressors in the past and expand on those successes.
- The therapist could use images and symbols to help the client see the problem in a helpful way. For example, the client might find a new job and throw himself completely into it. The therapist could tell him that he is a shining star: "You're shining bright right now. What can you do to keep shining?" This starts a discussion about how to last longer, work smarter, achieve more, and use restraint.
- The therapist might also focus on assisting the client to improve other aspects of his life.
- The client's continued belief in his own strength and basic goodness should be supported. The therapist should help him see himself as an individual who wants what's best for both himself and his family.
- One effective strategy is to encourage the client to adopt a "helper" role in some area of his life. This shifts the focus further from his view of himself as a helpless, incompetent addict to a strong, caring, competent person who can help others. This client's

participation in AA might give him the opportunity to help others in this manner.

As the end of the therapeutic process nears, the therapist helps the client prepare for the future. Following are suggestions for how the therapist can do this.

- *Prepare the client to maintain positive change through difficult times.* It is useful to convey the idea that the learning curve is never a straight slope; rather, it is a curvy line, with peaks and dips. There will be slips. It is unrealistic to expect perfection. Life will continuously have "ups and downs"—the goal is not to make things even but to cope effectively with these ups and downs.
- *Identify what the potential next stressors and challenges will be.* Work through the following question with the client: "Given what we've learned, how would you cope with the next stressor/challenge?"
- *Devote some time to preparing the client for changes to the environment.* For example, how will significant people in his life react to his change in behavior?
- *Ask the client to look into the future at the end of the treatment period and tell the therapist where he intends to be at a certain time (this is an Eriksonian approach).* The therapist could ask for a specific date when the client expects to get there and ask the client to call the therapist on that date. This process sets up an expectation of progress and accountability.

Ericksonian Therapy

All forms of strategic/interactional therapies have their roots in the work of Milton Erikson, an innovative psychotherapist who was one of the first theorists to suggest the importance of working within the client's "frame." With his unique use of hypnotherapy he fostered rapid changes in his clients, often in an indirect fashion. Through this work he came to emphasize unconscious factors in change and the importance of indirect ways to shift meanings and behavior. His approach is active, building on clients' resources to help them attain their goals. The therapist and client cooperate in building an awareness of the client's *experience* and an understanding of its *meaning*. Together, they build a context for change.

Erikson's interventions emphasize the following:

- *Suggestion* as a means of bypassing an impasse, reframing the problem, and taking a first step toward solving it
- *Metaphor* as indirect intervention—a way to help the client retrieve resources and create a unique response that builds a bridge for learning; the therapist uses the client's metaphors (e.g., if the client sees recovery as a road, then the therapist can speak of bridges or of smoothing the way, thus activating the client's imagination in the service of the change process)
- The *symptom* as a communication that conveys information about developmental needs
- An *orientation toward the future* (e.g., depression is seen as the result of focusing on past associations; as the client works toward change and begins to accomplish goals, she lets go of depression)
- Acquiring new *skills* to meet the requirements of new situations (such as the different ways of socializing associated with abstinence) and to handle developmental tasks
- The *cure* conceptualized as the loss of the symptom and as the development of new relational patterns that allow a creative response to the environment

While Erikson was able to work with virtually all clients using these techniques, his work has been especially useful in helping people let go of trauma, break through a

resistance to change, and alter obsessive-compulsive, phobic, or addictive behavior.

Solution-Focused Brief Therapy

Solution-focused brief therapy was developed by Steve De Shazer and his colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin. In solution-focused brief therapy, the emphasis is placed on building exceptions to the presenting problem and making rapid transitions to identifying and developing solutions intrinsic to the client or problem (Cooper, 1995). Basic tenets of this approach include the following:

- Focusing on competence rather than pathology
- Finding a unique solution for each person
- Using exceptions to the problem to open the door to optimism
- Using past successes to foster confidence
- Looking to the client as the expert
- Using goal-setting to chart a path toward change
- Sharing the responsibility for change with the client

The basic tenets of the solution-focused model are fairly simple; they are the same when used for treating substance abuse disorders as they are for treating other mental health concerns. A therapist uses these same principles for an individual client, family, or group. The therapist emphasizes finding solutions to a problem, not on discovering the cause or origins of the problem. According to Giorlando and Schilling,

> The innovative perspective of solution-focused therapy shifts the emphasis from problems to solutions, empowering the client to access her internal resources, strengths, and past successes, with therapist and client working collaboratively to achieve change in a shorter time than that required by traditional schools of psychotherapy (Giorlando and Schilling, 1996).

Berg and Miller relate the "central philosophy" of solution-focused therapy in the following three rules (Berg and Miller 1992, p. 17):

1. "If it ain't broke, don't fix it!"
2. Once you know what works, do more of it!
3. If it doesn't work, then don't do it again—do something different!

Solution-focused interviewing strategies include the following (based on Giorlando and Schilling, 1996), presented in a typical sequence. These strategies can be applied at different points in the therapeutic process as appropriate.

- Ask the "miracle question" (i.e., "If a miracle happened and [your condition] were suddenly not a problem for you, how would your life be different?").
- Ask about exceptions (e.g., "Are there ever times you see pieces of the miracle?").
- Explore differences between current status and the desired problem-free state (e.g., "What is the difference between the times when you can see pieces of the miracle and the times when you can see only the problem?").
- Use scaling to determine how well the client thinks things are going, how willing she is to work toward the "miracle," her confidence in her ability to change, and the steps needed to improve the situation from one rating on the scale to the next highest.
- Try taking "time-outs" and suggest to the client "While I step out, I want you to think of the next smallest step you could take that would bring you to the next number on the scale."
- Affirm client competencies (e.g., tell the client, "I am impressed you are sitting in that chair again after what you just went through"). Many of these clients have never had this success acknowledged before.

- Suggest tasks that the client can perform to improve her situation (e.g., ask her to do something achievable that would provide useful information or move her closer to the "miracle" she has chosen).

The MRI Therapeutic Model

The Mental Research Institute's brief therapy model is based on the belief that problems develop from, and are maintained by, the way that normal life difficulties are perceived and handled (Fisch et al., 1982). Normal difficulties become problems when an individual continually mishandles a situation, using the same ineffective approach each time. A client's belief system can cause him to develop ineffective approaches to problems that result in maintaining or even exacerbating the difficulty. The more the client uses an ineffective solution to solve a problem, the more the problem is reinforced and maintained. The solution lies in helping the client change his perception of the problem, then either modify the attempted solution so it has a greater chance of success or devise a more effective solution. These new solutions (generally referred to as *second order change*) work best if they are sufficiently different from the ineffective, previously attempted solutions.

In each session, practitioners using the MRI brief therapy model should try to do the following:

- *Define the problem in behavioral terms.* For example, a client may say, "I feel compelled to join the others at work in drinking, although as a result I have such a 'short fuse' that I get in fights and even hurt my wife."
- *Determine how the client understands the problem.* What is her "frame of reference" or "position"? It is important to understand how the client views her problem and what attitudes she has toward the problem. For example, a client might insist that her substance abuse is the result of pressures at work. However, the therapist notes that she began using after the death of her spouse and therefore hypothesizes that the substance abuse is related to her deep grief. The challenge for the therapist is to work with the client's position in a way that allows for a more useful understanding of the problem, and therefore for new, more effective solutions.
- *State goals.* What behaviors are to be changed and what would be the signs of change?
- *Review attempted solutions.* What has the client done to try to solve the problem? What has worked, and what has not worked?
- *Reframe the situation.* Help the client change his perception of himself, others involved, or the problem situation so that new options can appear.
- *Develop second order change.* Help the client generate more effective solutions that lead in a different direction from the ineffective ones—either by modifying attempted solutions or by developing new ones. In the case of a client who has tried to control her drinking by obsessing over her need to stop drinking, the therapist might perceive that every time she thinks about controlling her drinking she activates her fears that she is weak and out of control. The more she obsesses over controlling her drinking the more overwhelmed she becomes about the impossibility of the task. The therapist would try to help this client to stop obsessing over this task and instead view the situation as manageable and changeable in a step-wise fashion. The therapist would help her see that she has been strong and capable in other aspects of her life and that she can make use of these strengths and competencies to handle his drinking problem.
- *Plan for maintenance of the new behaviors.* Support continued improvement by preparing the client to meet future challenges and crises.

The speed with which a therapist is able to move through these steps will depend on the client's particular problem, overall development, cognitive capacities, and his stage of readiness to change.

Haley's Problem-Solving Therapy

Jay Haley wrote that "therapy can be called strategic if the therapist initiates what happens during the therapy and designs a particular approach for each problem" (Haley, 1973, p. 17). To do this the therapist will have to identify solvable problems, design interventions to resolve them, correct those interventions based on responses from the client, and evaluate the effectiveness of the therapy.

Haley's problem-solving therapy emphasizes obtaining a clear statement of the problem and an accurate picture of the interactional sequences that maintain it. Moreover, symptoms (i.e., presenting dysfunctions) or problem behaviors serve a function in families and carry metaphorical information about hierarchical dysfunction (Haley, 1987). Through observing the client's symptomatic behavior, the therapist can often understand the underlying problem metaphorically. For example, if a child runs away it can indicate that the family is "running away" from confronting an issue. This behavior often signals a solution as well, calling attention to what needs to be changed.

To map out a family's organization, the therapist should observe communication sequences—who talks to whom, and in what order. The therapist should try to answer questions such as, "What function does the symptom serve in stabilizing the family?" and, "What is the central theme around which the problem is organized?"

Haley's approach assumes that substance abuse by a family member is a symptom of a family's desire to avoid confronting dysfunctional family dynamics. The individual is not necessarily responsible for having created the symptom (which would fit in well with a disease concept addiction). According to Haley's model, a wife may drink to avoid expressing her rage at her husband for having an affair. The husband implicitly understands that by confronting his wife's drinking, a confrontation might ensue over his infidelity and that could destroy the marriage. This approach recommends negotiating a path to change by changing the family pattern that militates against it. The therapist could work with the family to set goals and design a strategic series of directives to meet these goals, usually involving a change in the sequences of interaction that maintain the problem. In the above example, the wife's drinking serves to stabilize the family and avoid the real issues of the wife's anger and the husband's infidelity. The therapist would work with the wife to express her anger in a way other than drinking, and define the issue as one of trust in the marriage.

6 Brief Humanistic and Existential Therapies

Humanistic and existential psychotherapies use a wide range of approaches to case conceptualization, therapeutic goals, intervention strategies, and research methodologies. They are united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Psychological problems (including substance abuse disorders) are viewed as the result of inhibited ability to make authentic, meaningful, and self-directed choices about how to live. Consequently, interventions are aimed at increasing client self-awareness and self-understanding.

Whereas the key words for humanistic therapy are *acceptance* and *growth*, the major themes of existential therapy are client *responsibility* and *freedom*. This chapter broadly defines some of the major concepts of these two therapeutic approaches and describes how they can be applied to brief therapy in the treatment of substance abuse disorders. A short case illustrates how each theory would approach the client's issues. Many of the characteristics of these therapies have been incorporated into other therapeutic approaches such as narrative therapy.

Humanistic and existential approaches share a belief that people have the capacity for self-awareness and choice. However, the two schools come to this belief through different theories. The humanistic perspective views human nature as basically good, with an inherent potential to maintain healthy, meaningful relationships and to make choices that are in the interest of oneself and others. The humanistic therapist focuses on helping people free themselves from disabling assumptions and attitudes so they can live fuller lives. The therapist emphasizes growth and self-actualization rather than curing diseases or alleviating disorders. This perspective targets present conscious processes rather than unconscious processes and past causes, but like the existential approach, it holds that people have an inherent capacity for responsible self-direction. For the humanistic therapist, not being one's true self is the source of problems. The therapeutic relationship serves as a vehicle or context in which the process of psychological growth is fostered. The humanistic therapist tries to create a therapeutic relationship that is warm and accepting and that trusts that the client's inner drive is to actualize in a healthy direction.

The existentialist, on the other hand, is more interested in helping the client find philosophical meaning in the face of anxiety by choosing to think and act authentically and responsibly. According to existential therapy, the central problems people face are embedded in anxiety over loneliness, isolation, despair, and, ultimately, death. Creativity, love, authenticity, and free will are recognized as

potential avenues toward transformation, enabling people to live meaningful lives in the face of uncertainty and suffering. Everyone suffers losses (e.g., friends die, relationships end), and these losses cause anxiety because they are reminders of human limitations and inevitable death. The existential therapist recognizes that human influence is shaped by biology, culture, and luck. Existential therapy assumes the belief that people's problems come from not exercising choice and judgment enough—or well enough—to forge meaning in their lives, and that each individual is responsible for making meaning out of life. Outside forces, however, may contribute to the individual's limited ability to exercise choice and live a meaningful life. For the existential therapist, life is much more of a confrontation with negative internal forces than it is for the humanistic therapist.

In general, brief therapy demands the rapid formation of a therapeutic alliance compared with long-term treatment modalities. These therapies address factors shaping substance abuse disorders, such as lack of meaning in one's life, fear of death or failure, alienation from others, and spiritual emptiness. Humanistic and existential therapies penetrate at a deeper level to issues related to substance abuse disorders, often serving as a catalyst for seeking alternatives to substances to fill the void the client is experiencing. The counselor's empathy and acceptance, as well as the insight gained by the client, contribute to the client's recovery by providing opportunities for her to make new existential choices, beginning with an informed decision to use or abstain from substances. These therapies can add for the client a dimension of self-respect, self-motivation, and self-growth that will better facilitate his treatment. Humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner resources, and establish the client as the person responsible for recovery. Thus, clients may be more likely to see beyond the limitations of short-term treatment and envision recovery as a lifelong process of working to reach their full potential.

Because these approaches attempt to address the underlying factors of substance abuse disorders, they may not always directly confront substance abuse itself. Given that the substance abuse is the primary presenting problem and should remain in the foreground, these therapies are most effectively used in conjunction with more traditional treatments for substance abuse disorders. However, many of the underlying principles that have been developed to support these therapies can be applied to almost any other kind of therapy to facilitate the client–therapist relationship.

Using Humanistic and Existential Therapies

Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's subjective experience) are useful in any type of brief therapy session, whether it involves psychodynamic, strategic, or cognitive–behavioral therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process.

While the approaches discussed in this chapter encompass a wide variety of therapeutic interventions, they are united by an emphasis on *lived* experience, authentic (therapeutic) relationships, and recognition of the subjective nature of human experience. There is a focus on helping the client to understand the ways in which reality is influenced by past experience, present perceptions, and expectations for the future. Schor describes the process through

which our experiences assume meaning as *apperception* (Schor, 1998). Becoming aware of this process yields insight and facilitates the ability to choose new ways of being and acting.

For many clients, momentary circumstances and problems surrounding substance abuse may seem more pressing, and notions of integration, spirituality, and existential growth may be too remote from their immediate experience to be effective. In such instances, humanistic and existential approaches can help clients focus on the fact that they do, indeed, make decisions about substance abuse and are responsible for their own recovery.

Essential Skills

By their very nature, these models do not rely on a comprehensive set of techniques or procedures. Rather, the personal philosophy of the therapist must be congruent with the theoretical underpinnings associated with these approaches. The therapist must be willing and able to engage the client in a genuine and authentic fashion in order to help the client make meaningful change. Sensitivity to "teachable" or "therapeutic" moments is essential.

When To Use Brief Humanistic and Existential Therapies

These approaches can be useful at all stages of recovery in creating a foundation of respect for clients and mutual acceptance of the significance of their experiences. There are, however, some therapeutic moments that lend themselves more readily to one or more specific approaches. The details of the specific approaches are laid out later in this chapter. *Client-centered* therapy, for example, can be used immediately to establish rapport and to clarify issues throughout the session. *Existential* therapy may be used most effectively when a client is able to access emotional experiences or when obstacles must be overcome to facilitate a client's entry into or continuation of recovery (e.g., to get someone who insists on remaining helpless to accept responsibility). *Narrative* therapy may be used to help the client conceptualize treatment as an opportunity to assume authorship and begin a "new chapter" in life. *Gestalt* approaches can also be used throughout therapy to facilitate a genuine encounter with the therapist and the client's own experience. *Transpersonal* therapy can enhance spiritual development by focusing on the intangible aspects of human experience and awareness of unrealized spiritual capacity. These approaches increase self-awareness, which promotes self-esteem and allows for more client responsibility, thus giving the client a sense of control and the opportunity to make choices. All of these approaches can be used to support the goals of therapy for substance abuse disorders.

Duration of Therapy and Frequency of Sessions

Although many aspects of these approaches are found in other therapeutic orientations, concepts like empathy, meaning, and choice lie at the very heart of humanistic and existential therapies. They are particularly valuable for brief treatment of substance abuse disorders because they increase therapeutic rapport and enhance conscious experience and acceptance of responsibility. Episodic treatment could be designed within this framework, with the treatment plan focusing on the client's tasks and experience between sessions. Humanistic and existential therapies assume that much growth and change occur outside the meetings. When focused on broader problems, these therapies can be lifelong journeys of growth and transformation. At the same time, focusing on specific substance abuse issues can provide a framework for change and more discrete goals. These techniques will also work well in conjunction with other types of therapy.

Initial Session

The opening session is extremely important in brief therapy for building an alliance, developing therapeutic rapport, and creating a climate of mutual respect. Although the approaches discussed in this chapter have different ways of addressing the client's problems, the opening session should attempt the following:

- Start to develop the alliance
- Emphasize the client's freedom of choice and potential for meaningful change
- Articulate expectations and goals of therapy (how goals are to be reached)

Developing the alliance can be undertaken through reflective listening, demonstrating respect, honesty, and openness; eliciting trust and confidence; and applying other principles that emerge from these therapies. The therapist's authentic manner of encountering the client can set the tone for an honest, collaborative therapeutic relationship. Emphasizing freedom of choice and potential for meaningful change may be deepened by a focus on the current decision (however it has been reached) to participate in the opening session. Expectations and goals can be articulated through strategic questions or comments like, "What might be accomplished in treatment that would help you live better" or "You now face the choice of how to participate in your own substance abuse recovery."

Because of time constraints inherent in approaches to brief substance abuse treatment, the early phase of therapy is crucial. Unless the therapist succeeds in engaging the client during this early phase, the treatment is likely to be less effective. "Engaging" includes helping the client increase motivation for other aspects of substance abuse treatment such as group therapy. Moreover, the patterns of interaction established during the early phase tend to persist throughout therapy. The degree of motivation that the client feels after the first session is determined largely by the degree of significance experienced during the initial therapeutic encounter. A negative experience may keep a highly motivated client from coming back, whereas a positive experience may induce a poorly motivated client to recognize the potential for treatment to be helpful.

Compatibility of Humanistic And Existential Therapies and 12-Step Programs

Humanistic and existential approaches are consistent with many tenets of 12-Step programs. For example, existential and humanistic therapists would embrace the significance stressed by the "serenity prayer" to *accept* the things that cannot be changed, the *courage* to change what can be changed, and the *wisdom* to know the difference. However, some would argue against the degree to which Alcoholics Anonymous (AA) identifies the person's "disease" as a central character trait, or the way in which some might interpret the notion of "powerlessness." The principles of existentialism, free choice, and free will may appear incompatible with the 12-Step philosophy of acceptance and surrender. Yet, such surrender must result from conscious decisions on an individual's part. The AA concept of rigorous self-assessment—of accepting one's own personal limitations and continually choosing and rechoosing to act according to certain principles as a way of living life—are compatible with both existential and humanistic principles.

Research Orientation

The predominant research strategy or methodology in social science is rooted in the natural science or rational–empirical perspective. Such approaches generally attempt to identify and demonstrate causal relationships by isolating specific variables while controlling

for other variables such as personal differences among therapists as well as clients. For example, variations in behavior or outcomes are often quantified, measured, and subjected to statistical procedures in order to isolate the researcher from the data and ensure objectivity. Such strategies are particularly useful for investigating observable phenomena like behavior. Traditional approaches to understanding human experience and meaning, however, have been criticized as an insufficient means to understanding the *lived* reality of human experience. Von Eckartsberg noted, "Science aims for an ideal world of dependent and independent variables in their causal interconnectedness quite abstracted and removed from personal experience of the everyday life-world" (Von Eckartsberg, 1983, p. 199). Similarly, Blewett argued, "The importance of human experience relative to behavior is beyond question for experience extends beyond behavior just as feeling extends beyond the concepts of language" (Blewett, 1969, p. 22). Thus, traditional methodological approaches seem ill-suited for understanding the meaning of human experience and the process by which self-understanding manifests itself in the context of a therapeutic relationship.

A humanistic science or qualitative approach, which has its roots in phenomenology, is claimed to be more appropriate for the complexities and nuances of understanding human experience (Giorgi, 1985). The personal and unique construction of meaning, the importance of such subtleties as "the relationship" and the "fit" in therapy, and shifts in internal states of consciousness can be quantified and measured only in the broadest of terms. A more subtle science is required to describe humans and the therapeutic process.

Rather than prediction, control, and replication of results, a humanistic science approach emphasizes understanding and description. Instead of statistical analysis of quantifiable data, it emphasizes narrative descriptions of experience. Qualitative understanding values uniqueness and diversity—the "little stories" (Lyotard, 1984)—as much as generalizability or grander explanations. Generally, this approach assumes that objectivity, such as is presumed in rational empirical methods, is illusory. For the qualitative researcher and the therapist, the goals are the same: openness to the other, active participation, and awareness of one's own subjectivity, rather than illusory objectivity. Intersubjective dialog provides a means of comparing subjective experiences in order to find commonality and divergence as well as to avoid researcher bias.

Because humanistic and existential therapies emphasize psychological process and the therapeutic relationship, alternative research strategies may be required in order to understand the necessary and sufficient conditions for therapeutic change. For example, Carl Rogers "presented a challenge to psychology to design new models of scientific investigation capable of dealing with the inner, subjective experience of the person" (Corey, 1991, p. 218). Some 50 years ago, he pioneered the use of verbatim transcripts of counseling sessions and employed audio and video taping of sessions long before such procedures became standard practice in research and supervision.

The Humanistic Approach to Therapy

Humanistic psychology, often referred to as the "third force" besides behaviorism and psychoanalysis, is concerned with human potential and the individual's unique personal experience. Humanistic psychologists generally do not deny the importance of many principles of behaviorism and psychoanalysis. They value the awareness of antecedents to behavior as well as the importance of childhood experiences and

unconscious psychological processes. Humanistic psychologists would argue, however, that humans are more than the collection of behaviors or objects of unconscious forces. Therefore, humanistic psychology often is described as holistic in the sense that it tends to be inclusive and accepting of various theoretical traditions and therapeutic practices. The emphasis for many humanistic therapists is the primacy of establishing a therapeutic relationship that is collaborative, accepting, authentic, and honors the unique world in which the client lives. The humanistic approach is also holistic in that it assumes an interrelatedness between the client's psychological, biological, social, and spiritual dimensions. Humanistic psychology assumes that people have an innate capacity toward self-understanding and psychological health.

Some of the key proponents of this approach include Abraham Maslow, who popularized the concept of "self-actualization," Carl Rogers, who formulated person-centered therapy, and Fritz Perls, whose Gestalt therapy focused on the wholeness of an individual's experience at any given moment. Some of the essential characteristics of humanistic therapy are

- *Empathic understanding* of the client's frame of reference and subjective experience
- *Respect* for the client's cultural values and freedom to exercise choice
- *Exploration of problems* through an authentic and collaborative approach to helping the client develop insight, courage, and responsibility
- *Exploration of goals and expectations*, including articulation of what the client wants to accomplish and hopes to gain from treatment
- *Clarification of the helping role* by defining the therapist's role but respecting the self determination of the client
- *Assessment and enhancement of client motivation* both collaboratively and authentically
- *Negotiation of a contract* by formally or informally asking, "Where do we go from here?"
- *Demonstration of authenticity* by setting a tone of genuine, authentic encounter

These characteristics may prove useful at all stages of substance abuse treatment. For example, emphasizing the choice of seeking help as a sign of courage can occur immediately; placing responsibility and wisdom with the client may follow. Respect, empathy, and authenticity must remain throughout the therapeutic relationship. Placing wisdom with the client may be useful in later stages of treatment, but a client who is currently using or recently stopped (within the last 30 days) may not be able to make reasonable judgments about his well-being or future.

Each therapy type discussed below is distinguished from the others by how it would respond to the case study presented in Figure 6-1.

Client-Centered Therapy

Carl Rogers' client-centered therapy assumes that the client holds the keys to recovery but notes that the therapist must offer a relationship in which the client can openly discover and test his own reality, with genuine understanding and acceptance from the therapist. Therapists must create three conditions that help clients change:

1. Unconditional positive regard
2. A warm, positive, and accepting attitude that includes no evaluation or moral judgment
3. Accurate empathy, whereby the therapist conveys an accurate understanding of the client's world through skilled, active listening

According to Carson, the client-centered therapist believes that

Figure 6-1

A Case Study

This case study will be referred to throughout this chapter. It will provide an example to which each type of humanistic or existential therapy will be applied.

Sandra is a 38-year-old African-American woman who has abused a number of substances, including cocaine, heroine, alcohol, and marijuana over the past 15 years. She left high school and was a prostitute for 5 years. Later she found a job as a sales clerk at a home furnishings store. Sandra had two children in her early twenties, a daughter who is now 15, and a son, aged 18. Because of her substance abuse problems, they live with other relatives who agreed to raise them. Sandra has been in treatment repeatedly and has remained substance free for the last 5 years, with several minor relapses. She has been married for 2 years, to Steve, a carpenter; he is substance free and supports her attempts to stay away from substances.

Last month she became symptomatic with AIDS. She has been HIV-positive for 5 years but had not developed any illnesses related to the disease. Sandra has practiced safe sex with her husband who knew of her HIV status. Recently, after learning from the physician at her clinic about her HIV symptoms, she began to "shoot up," which led her back into treatment. Out of fear, she came to the treatment center and asked to see a counselor at the clinic one day after work. She is worried about her marriage and that her husband will be devastated by this news. She is afraid she is no longer strong enough to stay away from drugs since discovering the onset of AIDS. She is also concerned about her children and her job. Uncertain of how she will keep on living, she is also terrified of dying.

- Each individual exists in a private world of experience in which the individual is the center.
- The most basic striving of an individual is toward the maintenance, enhancement, and actualization of the self.
- An individual reacts to situations in terms of the way he perceives them, in ways consistent with his self-concept and view of the world.
- An individual's inner tendencies are toward health and wholeness; under normal conditions, a person behaves in rational and constructive ways and chooses pathways toward personal growth and self-actualization (Carson, 1992).

A client-centered therapist focuses on the client's self-actualizing core and the positive forces of the client (i.e., the skills the client has used in the past to deal with certain problems). The client should also understand the unconditional nature of the therapist's acceptance. This type of therapy aims not to interpret the client's unconscious motivation or conflicts but to reflect what the client feels, to overcome resistance through consistent acceptance, and to help replace negative attitudes with positive ones.

Rogers' techniques are particularly useful for the therapist who is trying to address a substance-abusing client's denial and motivate her for further treatment. For example, the techniques of motivational interviewing draw heavily on Rogerian principles (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c], for more information on motivational interviewing).

Response to the case study

A client-centered therapist would engage in reflective listening, accepting the client and her past, and clarifying her current situation and feelings. As Sandra developed trust in the

therapist, he would begin to emphasize her positive characteristics and her potential to make meaningful choices to become the person she wants to (and can) become. Another goal of therapy would be to help her develop sufficient insight so that she can make choices that reflect more closely the values and principles to which she aspires. For example, she may want to tell her husband about her symptoms and try to strengthen her marriage.

If Sandra began to feel guilt about her past as a prostitute, the therapist would demonstrate appreciation of her struggle to accept that aspect of herself, highlighting the fact that she did eventually choose to leave it. He may note that she did the best she could at that time and underscore her current commitment to choose a better life. Sandra would be supported and accepted, not criticized. She would be encouraged to express her fear of death and the effect this fear has on her. This might be the first time in her life that someone has been unconditionally accepting of her or focused on her strengths rather than her failings. She apparently has the ability to solve problems, which is reflected by her return to therapy and her insight about needing help. By being understood and accepted, her self-esteem and sense of hope would increase and her shame would decrease. She would feel supported in making critical choices in her life and more confident to resume her recovery.

Narrative Therapy

Narrative therapy emerges from social constructivism, which assumes that events in life are inherently ambiguous, and the ways in which people construct meaning are largely influenced by family, culture, and society. Narrative therapy assumes that people's lives, including their relationships, are shaped by language and the knowledge and meaning contained in the stories they hear and tell about their lives. Recent approaches to understanding psychological growth have emphasized using storytelling and mythology to enhance self-awareness (see Campbell, 1968; Feinstein and Krippner, 1997; Middelkoop, 1989).

Parker and Horton argue that "Studies in a variety of disciplines...have suggested that all cognition is inherently metaphorical" and note "the vital role that symbolism plays in perception" (Parker and Horton, 1996, p. 83). The authors offer the "perspective that the universe is made up of stories rather than atoms" and suggest, "Myth and ritual are vehicles through which the value-impregnated beliefs and ideas that we live by, and for, are preserved and transmitted" (p. 82). From this perspective, narratives reveal a deeper truth about the meanings of our experience than a factual account of the events themselves. As Feinstein and Krippner note, "Personal mythologies give meaning to the past, understanding to the present, and direction to the future" (Feinstein and Krippner, 1997, p. 138).

When people tell and retell their life stories (with the help of a therapist), the stories evolve into increasingly meaningful and healing constructions. As narrative therapists listen to the stories clients tell, they assist them by identifying alternative ways of understanding events in their lives. Thus, they help clients to assume authorship of their lives in order to rewrite their stories by breaking patterns and developing new solutions. Narrative therapy helps clients resolve their problems by

- Helping them become aware of how events in their lives have assumed significance
- Allowing them to distance themselves from impoverishing stories by giving new meaning to their past
- Helping them to see the problem of substance abuse as a separate, influential entity rather than an inseparable part of who they are (note the discrepancy between this

and the AA member's statement, "My name is Jane, and I am an alcoholic")

- Collaboratively identifying exceptions to self-defeating patterns
- Encouraging them to challenge destructive cultural influences they have internalized
- Challenging clients to rewrite their own lives according to alternative and preferred scripts

Narrative therapy can be a powerful approach for engaging clients in describing their lives and providing them with opportunities to gain insight into their life stories and to change those "scripts" they find lacking. Storytelling is a way of articulating a subjective, experiential truth, and it is important for the therapist *and* client to become aware of the significance of the story being told and its potential therapeutic value.

Narrative approaches to psychological healing have been used across various cultures for thousands of years (Katz, 1993), but they have often been overlooked by mainstream mental health professionals. Contemporary approaches to narrative therapy recognize the importance of understanding how human experience becomes meaningful. A person's life is influenced by the narratives he constructs, which are in turn influenced by the narratives of those around him. Thus, therapy is viewed as a collaborative attempt to increase clients' awareness of the ways in which events in their lives become significant. In effect, the therapist says, "Let's be curious about your story together."

The narrative approach often involves posing questions in a way that situates the problem as an external influence. "When the problem is externalized, it's as if the person can peek out from behind it" (Nichols and Schwartz, 1998, p. 412). In substance abuse treatment, for example, a client might be asked, "How has substance abuse influenced your life?" or "Have there been times when you did not allow addiction to take over?" Such questions can help identify positive aspects and potential resources occurring in people's narratives that can be enhanced, as well as deficits that must be overcome.

In an effort to be understood, clients sometimes tell a story as a way of educating the therapist to their culture or lifestyle. Therefore, it is essential for the therapist to appreciate the unique influences (positive and negative) of the client's specific cultural experiences and identity. Often these stories do not constitute sharing in its usual meaning. When listening to them, one may sense that these stories have been told repeatedly over the years. It is through this sense of storytelling—as oral history—that we reveal our values, expectations, hopes, and fears. For the therapist, a story provides insight into the clients' responses, their need to act on the responses, and their desire to be heard or understood. A story can become a way for a client to become both participant and observer in order to find new solutions or break down barriers.

Response to the case study

The therapist may initially ask Sandra to describe some of the important transitional moments in her life. These may include examples of loss of innocence occurring early in her life, her experience of school, circumstances and influences surrounding prostitution and drug use, the experience of being supported by her husband, and internal resources that enabled her to enter treatment and maintain sobriety. The therapist would ask questions about expectations she felt from family, society, and herself. She may be asked questions like, "How did addiction interfere with your attempts to be a good mother" or "How has fear contributed to your recent relapse and feelings of hopelessness?" Positive aspects of her story and exceptions to destructive aspects of her narrative could be identified by asking questions like, "Were there times that you didn't allow addiction to make choices for you?" and

"How has your ability to accept love and support from your husband helped you?"

The focus of therapeutic dialog could then shift toward developing alternatives to hopeless aspects of personal and cultural expectations. It would be helpful to remind her that recent advances in medical treatments mean that AIDS may not be the death sentence it was once thought to be. Other important questions can help her to begin to create an alternative story: "As you begin to understand the positive and negative influences in your life, what qualities must you possess in order to remain sober and develop better relationships with your husband and children?" She may need help replacing these stories with more positive narratives about herself. As Sandra talks about the people and events in her life, such as her childhood and her children, she can discover some of her feelings, as well as the personal meaning in her story. She can experience a great deal of healing through the therapist's feedback and questions that uncover the desires and emotions beneath her story. A continued focus on identifying, practicing, or even imagining changes in her story can begin the process of developing new ways of living.

Transpersonal Therapy

Transpersonal psychology emerged as a "fourth force" in psychology in the late 1960s and has strong roots in humanistic and existential psychologies, Jungian analysis, the East–West dialog, and ancient wisdom traditions. Transpersonal therapy may be thought of as a bridge between psychological and spiritual practice.

A transpersonal approach emphasizes development of the individual beyond, but including, the ego. It acknowledges the human spiritual quest and recognizes the human striving for unity, ultimate truth, and profound freedom. It cultivates intuitive ways of knowing that complement rational and sensory modes. This approach also recognizes the potential for growth inherent in "peak" experiences and other shifts in consciousness. Although grounded in psychological theory, transpersonal practitioners also tend to incorporate perspectives from ancient wisdom traditions.

The practice of transpersonal therapy is defined more by its orientation and scope rather than by a particular set of techniques or methods (Boorstein, 1980). Wittine suggests five postulates for a transpersonal psychotherapy (Wittine, 1989):

1. Transpersonal psychotherapy is an approach to healing and growth that recognizes the centrality of the self in the therapeutic process.
2. Transpersonal psychotherapy values wholeness of being and self-realization on all levels of the spectrum of identity (i.e., egoic, existential, transpersonal).
3. Transpersonal psychotherapy is a process of awakening from a limited personal identity to expanded universal knowledge of self.
4. Transpersonal psychotherapy makes use of the healing restorative nature of subjective awareness and intuition in the process of awakening.
5. In transpersonal psychotherapy, the therapeutic relationship is a vehicle for the process of awakening in both client and therapist.

Integrating insights and practices in everyday life is the goal of every therapy. Bringing the transpersonal dimension to the forefront may involve the following:

- Exploration of "inner voices" including those of a higher self that provides guidance for growth of the individual (Rowan, 1993)
- Refinement of intuition or nonrational knowing
- Practice of creativity in "formal" (art) or informal (personal relationships) encounters

- Meditation
- Loving service
- Cultivation of mindfulness
- Use of dreams and imagery

These techniques may be taught and supported explicitly in the therapy session. At times, a therapist may directly cultivate shifts in consciousness (e.g., through meditation [Weil, 1972], or imaginal work [Johnson, 1987]), providing immediate insight and inspiration that may not be available through more conventional means (Hart, 1998). This may provide clients with a skill they can practice on their own; initiating such activity represents a potential for brief intervention.

Transpersonal therapy recognizes the need for basic psychological development to be integrated with spiritual growth (Nelson, 1994). Without such integration there is danger of "spiritual bypassing," where issues of basic psychological functioning are avoided in the name of spiritual development. In other words, the basic psychological work should be undertaken first.

Substance abuse disorders may be seen broadly as an attempt to fill a spiritual void. They may also be understood as a means for the ego to defend itself against a natural drive for growth. If growth were to occur, the ego might find its dominance relinquished. Addiction, like spirituality, also raises questions of surrender (May, 1991): for example, to what and to whom do we surrender? In a culture and a psychology that are dominated by issues of rational ego control, what is the role of constructive surrender (regularly described in spiritual traditions)? How does constructive surrender become destructive and distorted in substance dependency? In addition, substance abuse may be understood as a means for shifting out of a normal waking state of consciousness. This may be an attempt to fulfill an innate drive (Weil, 1972) for nonrational consciousness.

Response to the case study

As the existentialists remind us, there is nothing like death to rivet our attention. A glimpse of death—for example, seeing the aftermath of a serious car crash—reminds the witness of how valuable life is, bringing up other issues as well. Sandra is now confronted with death due to AIDS. This opportunity to face death and life squarely provides a chance to reconsider and reprioritize her life. In fact, it could be argued that the best catalyst to brief therapy may be a death sentence precisely because it has the potential to wake up an individual. In many respects, helping the client wake from habitual, mechanical routines that are often based on ego protection and move toward an appreciation that the individual is not bound to or defined by a limited ego, is the goal of transpersonal therapy. This can be seen as a transformation of identity.

Many inspiring instances of people facing death, including death through AIDS, have shown that emergent spirituality can change the quality and direction of existence very quickly. For treatment, the basic sharing of these experiences with a group of others in a similar predicament often quickly moves the client beyond isolation and a sense of self-separateness to connect intimately with others who understand her situation. This community may not only bring comfort and support but also a deep sense of communion with humanity. In this instance, breaking through the shell of isolation may enable Sandra to begin to make new connections with her family and with herself. A sense of interconnection, a central postulate and experience in the wisdom traditions, may replace her perceived isolation.

Sandra may use this opportunity of facing possible death to begin to encounter and let go of such feelings as guilt, shame, disappointment, and anger that have kept her life less satisfying than it could be. Accessing the imaginal through art or dreams, for example, can provide

a clear and symbolic expression of unresolved issues. The use of rituals or rites-of-passage inspired by the wisdom traditions can provide some catalyst for shifting her consciousness through forgiveness and release.

The therapist may engage in a wide variety of methods (e.g., imagery, art, or dream work, meditation, rituals), but the heart of the work is in the simple and humane spirituality that is embodied by the therapist's loving presence along with the therapist's openness to explore the full range of human experience directly. For Sandra, this experience may be seen as an opportunity for practicing love and forgiveness, moving out from behind rigid self-separateness, facing fears, and transforming her self-definition.

Gestalt Therapy

Gestalt theory holds that the analysis of parts can never provide an understanding of the whole. In a therapeutic setting, this approach opposes the notion that human beings can be understood entirely through a rational, mechanistic, scientific process. The proponents of Gestalt therapy insist that the experiential world of a client can be understood only through that individual's direct experience and description. Gestalt therapists seek to help their clients gain awareness of themselves and the world. Discomfort arises from leaving elements and experiences of the psyche incomplete—primarily past relationships and intrapsychic conflicts that are unresolved, which Perls calls "unfinished business" (Perls, 1969). According to Gestalt theory

- The organism should be seen as a whole (physical behavior is an important component, as is a client's mental and emotional life).
- Being in the "here and now" (i.e., being aware of present experience) is of primary importance.
- How is more important than why (i.e., causes are not as important as results).
- The individual's inner experience is central.

For Gestalt therapists the "power is in the present" (Polster and Polster, 1973). This means that the "now" is the only place where awareness, responsibility, and change can occur. Therefore, the process of therapy is to help the client make contact with the present moment.

Rather than seeking detailed intellectual analysis, the Gestalt therapist looks to create a "safe emergency" in the therapeutic encounter. Perls' invocation to "lose your mind and come to your senses" implies that a feeling-level, "here and now" experience is the optimal condition for therapeutic work. This may be accomplished in a fairly short amount of time by explicitly asking clients to pay attention (e.g., "What are you aware of now? How does your fear feel to you?"). The therapist may point out how the client could be avoiding the present moment through inauthentic "games" or ways of relating such as "talking about" feelings rather than experiencing them directly. Clients may be asked to exaggerate certain expressions (e.g., pounding a fist) or role-play certain internal dialogs (e.g., through an empty chair technique). These may all serve the goal of helping clients move into the immediacy of their experience rather than remaining distant from it through intellectualization or substance abuse.

The term *contact* in Gestalt refers to meeting oneself and what is other than oneself. Without appropriate contact and contact boundaries there is no real meeting of the world. Instead, one remains either engulfed by the world on one hand or, on the other hand, distant from the world and people.

Substance abuse interrupts the flow of what Perls called "organismic self-regulation." The result is that individuals do not achieve satisfaction of their needs and can remain unaware of what their needs are. The substance

abuser may distort or thwart the natural cycle at any of the following points:

- Experiencing the need
- Mobilization of energy
- Contact
- Satisfaction
- Withdrawal
- Rest

Treatment involves bringing awareness to each of these dimensions and the client's strategies of avoidance.

Substance abuse may also be understood as "introjection" in which the client attempts to "swallow whole" or "drink in" his environment without contact and discrimination. This type of client bypasses and blocks other experiences that might enable contact and the development of discrimination. Perls maintains that such a client seeks immediate confluence without preparatory contact. This pattern of interaction extends to other relationships (besides the substance) as well.

In order for this work to proceed, the therapist must maintain a fine-tuned, present-moment immediacy, even serving as a "resonance chamber" (Polster and Polster, 1973) for the client's experience. They, too, must be able to make and sustain contact with the client and with their own reactions.

Response to the case study

The Gestalt therapist begins with Sandra's current experience of the world, starting with awareness and attention. The therapist may simply help her become aware of basic sights, sounds, somatic reactions, feelings, and thoughts as well as what her attention drifts to. The immediate contact between therapist and client is a component of the "now" where these sensations are explored directly. The therapist might notice and ask about her style of eye contact, or her fidgeting body, or stream of thoughts (e.g., "What is it like to make eye contact now? What is the sensation in your body at this moment?").

Sandra may also identify certain issues such as substance abuse, relationship difficulties, and the threat of death from AIDS that seem to dominate her life. The therapist might invite her to name and explore the sensation that the thought of death, for example, brings; perhaps this involves a sense of a void, or feeling cold and dark, or a feeling of engulfment. She then may be asked to become these sensations—for example, the therapist may ask her to be "the void" and encourage her to speak as if she were that void. This may then open possibilities for a dialog with the void through acting out the opposite polarity: separateness and choice. This might involve using an empty chair technique in which the client would literally move into the chair of the "void," speak as if she were that, and then move into an opposite chair and respond in a dialog. A therapist could also explore her introjection through questions such as, "How is this void different or the same as from the feeling of alcohol or in relationships with your children or husband?" She might also use this same technique to dialog with family members, or certain aspects of herself.

Sandra seems to have a great deal of "unfinished business" that involves unexpressed feelings (e.g., anger, longing, hurt). Experimentation with these sensations may begin to free her to express and meet these feelings more directly. All of this work encourages Sandra's experimentation with new ways of relating both during and outside of the session in order to move into the "here and now" and work toward the resolution of "unfinished business."

The Existential Approach To Therapy

The existential approach to therapy emphasizes the following six propositions:

1. All persons have the capacity for self-awareness.
2. As free beings, everyone must accept the responsibility that comes with freedom.
3. Each person has a unique identity that can only be known through relationships with others.
4. Each person must continually recreate himself. The meaning of life and of existence is never fixed; rather, it constantly changes.
5. Anxiety is part of the human condition.
6. Death is a basic human condition that gives significance to life.

The core question addressed in existential therapy is "How do I exist?" in the face of uncertainty, conflict, or death. An individual achieves authenticity through courage and is thus able to define and discover his own meaning in the present and the future. There are important choices to be made (e.g., to have true freedom and to take responsibility for one's life, one must face uncertainty and give up a false sense of security).

A core characteristic of the existential view is that an individual is a "being in the world" who has biological, social, and psychological needs. Being in the world involves the physical world, the world of relationships with others, and one's own relationship to self (May and Yalom, 1995, p. 265). The "authentic" individual values symbolization, imagination, and judgment and is able to use these tools to continually create personal meaning.

Existential therapy focuses on specific concerns rooted in the individual's existence. The contemporary existential psychotherapist, Irvin Yalom, identifies these concerns as *death, isolation, freedom,* and *emptiness.* Existential therapy focuses on the anxiety that occurs when a client confronts the conflict inherent in life. The role of the therapist is to help the client focus on personal responsibility for making decisions, and the therapist may integrate some humanistic approaches and techniques. Yalom, for example, perceives the therapist as a "fellow traveler" through life, and he uses empathy and support to elicit insight and choices. He strongly believes that because people exist in the presence of others, the relational context of group therapy is an effective approach (Yalom, 1980).

Preliminary observations and research indicate individuals with low levels of perceived meaning in life may be prone to substance abuse as a coping mechanism. Frankl first observed this possibility among inpatient drug abusers in Germany during the 1930s (Frankl, 1959). Nicholson and colleagues found inpatient drug abusers had significantly lower levels of meaning in life when compared to a group of matched, nonabusing control subjects (Nicholson et al., 1994). Shedler and Block performed a longitudinal study and found that lower levels of perceived life meaning among young children preceded substance abuse patterns in adolescence (Shedler and Block, 1990).

In the context of treating substance abuse disorders, the existential therapist often serves as a coach helping the client confront the anxiety that tempts him to abuse substances. The client is then focused on taking responsibility and making his own choices to remain substance free. If he chooses to avoid the anxiety through substances, he cannot move forward to find truth and authenticity. The challenge for the existential therapist is to help the client make personal decisions about how to live, drawing upon creativity and love, instead of letting outside events determine behavior.

Time and Existential Therapy

Although existential therapy may not have been designed for practice in a time-limited fashion, its underlying principles relating to the client's struggle for meaning in the face of death can be applied to a time-limited setting. Brief therapy

(no matter what the modality) must be concerned with the "here and now." Both existential and brief therapies are also concerned with the limitations of time. Hoyt suggests that in brief therapy time should always be an issue for discussion, and the therapist should make a point of reminding the client of his use of time and the time scheduled for terminating therapy (Hoyt, 1995).

Mann's model of time-limited psychotherapy (Mann, 1973; Mann and Goldman, 1994), although based in part on psychodynamic theory, also uses an existential approach to the primacy of time. In Mann's approach, the time limitation of brief therapy is emphasized to help the client confront issues of separateness and isolation. This facilitates the client's becoming engaged in and responsible for the process of recovery.

Response to the case study

An existential therapist may help Sandra understand that her diagnosis of AIDS forces her to confront the possibility of death and, consequently, face the responsibilities thrust upon her by life. The therapist could accomplish this by helping her understand that her life (like everyone else's) is finite. Therefore, she is challenged to forge meaning from her life and make difficult decisions about her relationships and ways of dealing (or *not* dealing) with choices about substance abuse. The focus in her therapy would be on choosing the life she wants to live. The therapist would assist her in dealing constructively with anxiety so that she can find meaning in the rest of her life. This could be accomplished by engaging her in the struggle to assume authorship of her choices. She may be encouraged to "play out" scenarios of choices she faces and acknowledge the accompanying fears and anxieties. She might be asked, "What keeps you from sharing your fears with your husband, and accepting the possibility of his support?" or "Imagine yourself expressing your love for your children and regret for the mistakes you have made." Thus, the therapist would help her understand that making difficult choices in the face of death is actually a way to find integrity, wholeness, and meaning.

The teachings of the existential therapist, Yalom, can be a useful resource in dealing with issues related to death, since he has worked with terminally ill cancer patients for many years, helping them to use their crisis and their danger as an opportunity for change (Yalom, 1998). Yalom explains that although death is a primary source of anxiety for a client, incorporating death into life can enrich life and allow one to live more purposefully.

7 Brief Psychodynamic Therapy

Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behavior. The goals of psychodynamic therapy are client self-awareness and understanding of the influence of the past on present behavior. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and desire to abuse substances.

Several different approaches to brief psychodynamic psychotherapy have evolved from psychoanalytic theory and have been clinically applied to a wide range of psychological disorders. A growing body of research supports the efficacy of these approaches (Crits-Christoph, 1992; Messer and Warren, 1995).

Short-term psychodynamic therapies can contribute to the armamentarium of treatments for substance abuse disorders. Brief psychodynamic therapies probably have the best chance to be effective when they are integrated into a relatively comprehensive substance abuse treatment program that includes drug-focused interventions such as regular urinalysis, drug counseling, and, for opioid-dependents, methadone maintenance pharmacotherapy. Brief psychodynamic therapies are perhaps more helpful after abstinence is well established. They may be more beneficial for clients with no greater than moderate severity of substance abuse. It is also important that the psychodynamic therapist know about the pharmacology of abused drugs, the subculture of substance abuse, and 12-Step programs.

Psychodynamic therapy is the oldest of the modern therapies. As such, it is based in a highly developed and multifaceted theory of human development and interaction. This chapter demonstrates how rich it is for adaptation and further evolution by contemporary therapists for specific purposes. The material presented in this chapter provides a quick glance at the usefulness and the complex nature of this type of therapy.

Background

The theory supporting psychodynamic therapy originated in and is informed by psychoanalytic theory. There are four major schools of psychoanalytic theory, each of which has influenced psychodynamic therapy. The four schools are: Freudian, Ego Psychology, Object Relations, and Self Psychology.

Freudian psychology is based on the theories first formulated by Sigmund Freud in the early part of this century and is sometimes referred to as the drive or structural model. The essence of Freud's theory is that sexual and aggressive energies originating in the *id* (or unconscious) are modulated by the *ego*, which is a set of functions that moderates between the id and external reality. Defense mechanisms are

constructions of the ego that operate to minimize pain and to maintain psychic equilibrium. The *superego*, formed during latency (between age 5 and puberty), operates to control id drives through guilt (Messer and Warren, 1995).

Ego Psychology derives from Freudian psychology. Its proponents focus their work on enhancing and maintaining ego function in accordance with the demands of reality. Ego Psychology stresses the individual's capacity for defense, adaptation, and reality testing (Pine, 1990).

Object Relations psychology was first articulated by several British analysts, among them Melanie Klein, W.R.D. Fairbairn, D.W. Winnicott, and Harry Guntrip. According to this theory, human beings are always shaped in relation to the significant others surrounding them. Our struggles and goals in life focus on maintaining relations with others, while at the same time differentiating ourselves from others. The internal representations of self and others acquired in childhood are later played out in adult relations. Individuals repeat old object relationships in an effort to master them and become freed from them (Messer and Warren, 1995).

Self Psychology was founded by Heinz Kohut, M.D., in Chicago during the 1950s. Kohut observed that the self refers to a person's perception of his experience of his self, including the presence or lack of a sense of self-esteem. The self is perceived in relation to the establishment of boundaries and the differentiations of self from others (or the lack of boundaries and differentiations). "The explanatory power of the new psychology of the self is nowhere as evident as with regard to...the addictions" (Blaine and Julius, 1977, p. vii). Kohut postulated that persons suffering from substance abuse disorders also suffer from a weakness in the core of their personalities—a defect in the formation of the "self." Substances appear to the user to be capable of curing the central defect in the self.

> [T]he ingestion of the drug provides him with the self-esteem which he does not possess. Through the incorporation of the drug, he supplies for himself the feeling of being accepted and thus of being self-confident; or he creates the experience of being merged with the source of power that gives him the feeling of being strong and worthwhile (Blaine and Julius, 1977, pp. vii–viii).

Each of the four schools of psychoanalytic theory presents discrete theories of personality formation, psychopathology formation, and change; techniques by which to conduct therapy; and indications and contraindications for therapy. Psychodynamic therapy is distinguished from psychoanalysis in several particulars, including the fact that psychodynamic therapy need not include all analytic techniques and is not conducted by psychoanalytically trained analysts. Psychodynamic therapy is also conducted over a shorter period of time and with less frequency than psychoanalysis.

Several of the brief forms of psychodynamic therapy are considered less appropriate for use with persons with substance abuse disorders, partly because their altered perceptions make it difficult to achieve insight and problem resolution. However, many psychodynamic therapists work with substance-abusing clients, in conjunction with traditional drug and alcohol treatment programs or as the sole therapist for clients with coexisting disorders, using forms of brief psychodynamic therapy described in more detail below.

Introduction to Brief Psychodynamic Therapy

The healing and change process envisioned in long-term psychodynamic therapy typically requires at least 2 years of sessions. This is because the goal of therapy is often to change an

aspect of one's identity or personality or to integrate key developmental learning missed while the client was stuck at an earlier stage of emotional development.

Practitioners of brief psychodynamic therapy believe that some changes can happen through a more rapid process or that an initial short intervention will start an ongoing process of change that does not need the constant involvement of the therapist. A central concept in brief therapy is that there should be one major focus for the therapy rather than the more traditional psychoanalytic practice of allowing the client to associate freely and discuss unconnected issues (Malan, 1976). In brief therapy, the central focus is developed during the initial evaluation process, occurring during the first session or two. This focus must be agreed on by the client and therapist. The central focus singles out the most important issues and thus creates a structure and identifies a goal for the treatment. In brief therapy, the therapist is expected to be fairly active in keeping the session focused on the main issue. Having a clear focus makes it possible to do interpretive work in a relatively short time because the therapist only addresses the circumscribed problem area. When using brief psychodynamic approaches to therapy for the treatment of substance abuse disorders, the central focus will always be the substance abuse in association with the core conflict. Further, the substance abuse and the core conflict will always be conceptualized within an interpersonal framework.

The number of sessions varies from one approach to another, but brief psychodynamic therapy is typically considered to be no more than 25 sessions (Bauer and Kobos, 1987). Crits-Christoph and Barber included models allowing up to 40 sessions in their review of short-term dynamic psychotherapies because of the divergence in the scope of treatment and the types of goals addressed (Crits-Christoph and Barber, 1991). For example, some brief psychodynamic models focus mainly on symptom reduction (Horowitz, 1991), while others target the resolution of the Oedipal conflict (Davanloo, as interpreted by Laikin et al., 1991). The length of therapy is usually related to the ambitiousness of the therapy goals. Most therapists are flexible in terms of the number of sessions they recommend for clinical practice. Often the number of sessions depends on a client's characteristics, goals, and the issues deemed central by the therapist.

Psychodynamic Psychotherapy for Substance Abuse

Supportive-expressive (SE) psychotherapy (Luborsky, 1984) is one brief psychodynamic approach that has been adapted for use with people with substance abuse disorders. It has been modified for use with opiate dependence in conjunction with methadone maintenance treatment (Luborsky et al., 1977) and for cocaine use disorders (Mark and Faude, 1995; Mark and Luborsky, 1992). There have been many studies of the use of SE therapy for substance abuse disorders, resulting in a significant body of empirical data on its effectiveness in treating these problems (see below).

Mark and Faude asserted that although their therapeutic approach was devised specifically for cocaine-dependent clients, these people often have multiple dependencies, and this approach can be used to treat a variety of substance abuse disorders. However, clients should be reasonably stable in terms of their substance abuse before beginning this type of therapy (Mark and Faude, 1995).

Mark and Faude theorized that substances of abuse substitute a "chemical reaction" in place of experiences and that these chemically induced experiences can block the impact of

other external events. The person with a substance abuse disorder will therefore have a "tremendously impoverished and impaired capacity to experience," and traditional psychotherapy might have to be augmented with techniques that focus on increasing a client's ability to experience (Mark and Faude, 1995, p. 297).

Effective SE therapy depends on appropriate use of what is termed the *core conflictual relationship theme* (CCRT), a concept first introduced by Lester Luborsky. According to Luborsky, a CCRT is at the center of a person's problems. The CCRT develops from early childhood experiences, but the client is unaware of it and how it developed. It is assumed that the client will have better control over behavior if he knows more about what he is doing on an unconscious level. This knowledge is acquired by better understanding of childhood experiences (Bohart and Todd, 1988). The CCRT develops out of a *core response from others* (RO), which represents a person's predominant expectations or experiences of others' internal and external reactions to herself, and a *core response of the self* (RS), which refers to a more or less coherent combination of somatic experiences, affects, actions, cognitive style, self-esteem, and self-representations.

Most people with substance abuse disorders have particularly negative expectations of others' attitudes toward them (that is, the RO), although it remains unclear which came first—this response or the substance abuse disorder. Either way, the two become mutually reinforcing. Following are examples of statements that reflect the core RO of a person with a substance abuse disorder:

- "Everybody hates me."
- "I am just being used."
- "People laugh at me."
- "No one understands how I feel."
- "Everybody wants me to be something I'm not."
- "They're just waiting for me to make a fool of myself."

For many people with substance abuse disorders, alcohol or drug use is a way of self-medicating against feelings of low self-worth and low self-esteem that reflect the client's RS. A negative RO reinforces a negative RS and can lead to the deceptive and manipulative behavior that is sometimes observed in this population. The client's RS is based on the individual's somatic experiences, actions, and perceived needs. Following are examples of statements that could reflect a client's core RS:

- "I'm so stupid and gullible."
- "I can't do anything right."
- "If I didn't use drugs, I would lose my mind."
- "I can't help myself."
- "I'm not a very nice or honest person."

A third component of CCRT is a person's *wish*; it reflects what the client yearns for, wishes for, or desires. The client's "wish" is largely based on individual personality style. Those with substance abuse disorders often have a wish to continue using the substance without having to endure the consequences. Put another way, they would like to be accepted (or loved or appreciated) as they are, without having to give up the pleasure they get from their use (Levenson et al., 1997). Many people who have substance abuse disorders have much invested in denying that they really have a problem, in portraying themselves as helpless victims, and in disclaiming their role in the behavior that has brought them into treatment.

Once therapy has been initiated, the therapist and client can work together to put the client's goals into the CCRT framework and explore the meaning, function, and consequence of her substance abuse, looking in particular at how the RO and RS have contributed to the problem. The CCRT framework also can be used to identify potential obstacles in the recovery

process as the therapist and client explore the client's anticipated responses from others and from herself and discuss how these perceptions will change when she stops abusing substances.

The CCRT concept also can help clients deal with relapse, which is regarded by virtually all experts in the field as an integral and natural part of recovery. Relapse offers the client and the SE therapist the opportunity to examine how the RO and RS can serve as triggers and to devise strategies to avoid these triggers in the future. Finally, SE therapy is conducive to client participation in a self-help group such as Alcoholics Anonymous, or it can be used as a mechanism to examine a client's unwillingness to participate in these groups.

Stella and Christopher: A Case Study

The case study in this section came from the NIDA Collaborative Cocaine Study (Mark and Faude, 1997; adapted with permission). SE is the therapeutic approach used.

While dependent and impulsive, Stella, a 28-year-old cocaine-dependent woman, would be seen under many circumstances as warm and open. She appears to be the kind of person who wears her heart on her sleeve, but it is a big heart nonetheless, capable of caring for others with loyalty and compassion. In addition, she has a tenacity of spirit; despite a horrific personal history she completed her training as a medical technician and has worked in that capacity for much of the last 4 years. Her therapist, Christopher, is a well-trained psychodynamically oriented therapist. He is an intelligent, serious, and measured person, whose well-meaning nature comes through under most circumstances despite his natural reserve.

Stella has a history of polysubstance abuse, including the abuse of prescription drugs, both anxiolytics and opioids. She worked as a medical technician until she injured her back 3 months ago. At the beginning of treatment, she told Christopher that she was going to request medication from her physician for her back pain. After her eighth session, with her reluctant agreement, Christopher informed the physician that she was in treatment for cocaine dependence. Christopher asked the physician to find a medication other than diazepam (Valium) for Stella's back pain.

Stella began the 19th session complaining that ever since the physician found out she was a drug user, he has treated her differently. "He thinks I'm a scumbag drug addict," she said. Christopher acted uncharacteristically: he offered some advice. He suggested that Stella consider telling her physician how she feels about his treatment. The intervention strikingly altered the mood and productivity of the session. After a brief expression of sympathy for her position, he focused on her extreme distress over the physician's treatment. He attempted to explain the intensity of her reaction in terms of projection: that she responded so strongly because of her negative view of herself.

Matters got worse as the session continued. Stella related a second negative incident when she described her treatment by the physician in a group therapy session. The group therapist responded, "Well, you manipulate doctors!" Stella had been furious.

Christopher encouraged her to say more. Stella became frustrated at Christopher's lack of understanding and explained that again, she felt she was being treated like a "scumbag," this time by the group therapist. Christopher suggested that Stella might tell both the physician and the group therapist how she felt. The tension in the session disappeared, and Stella remarked that she has always had trouble sticking up for herself.

In supervision, Christopher realized immediately that he was indirectly letting Stella know that he understood and agreed with her.

Diagnostically speaking, Stella has a borderline personality disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition [DSM-IV] (American Psychiatric Association, 1994). When she was between 6 and 8 years old, Stella's maternal grandfather sexually abused her. Her parents divorced when she was 10, and she lived with her mother, who was often drunk and physically abusive. Stella said she was closer to her father, whom she described as gentle. He appeared to others as weak and ineffectual.

At age 15, Stella ran off with a boyfriend who was also her pimp. After 2 weeks she returned home, was unable to leave her mother, and was diagnosed as having agoraphobia, for which she took chlordiazepoxide (Librium). Two years later she ran away with another man, a particularly sadistic pimp. For 5 years she was too terrified to leave him. It was during this period that she started using cocaine.

The cocaine both "disclaims action" and affirms her "badness." Her cocaine use enabled her to avoid examining why she stayed with her boyfriend and simultaneously affirmed her badness. So, she deserves her fate. She would use the cocaine to clear her painful feelings and feel "strong and independent," then "feel like a big baby for having to use the drugs." She thought of herself as a "big baby," for returning to her mother at age 15 and for being unable to leave her current boyfriend. Her reactions to cocaine are typical; a brief surge or a "high," followed by a crash. However, these typical reactions also fit her core theme: she wants to be loved and cared for but believes she will be thwarted and exploited by others because of this wish. Her response then is to use drugs, which makes her feel strong and independent for a brief time and also makes her see herself as deserving of being thwarted and exploited, which has happened repeatedly in interpersonal contexts in her life.

Stella's drug use became a part of the therapy in two ways. In the first session, Stella told Christopher that she had taken chlordiazepoxide for several days before their appointment, to relieve her anxiety. She pointed out that it had been prescribed by a doctor. Presumably, Christopher would have known the results of her drug screen, which was part of the program. She thus confessed before being confronted by drug screen results. Her claim that the prescription was legitimate facilitated her denial that she has anything to be concerned about.

Second, Stella announced her intention to ask her physician for diazepam, a commonly abused medication. By contacting her physician, Christopher replayed a common scenario in her life: she signals that someone should take control or care for her, then resents it when they do, feeling that she is being treated like a "scumbag drug addict." She can create the largely illusory sense of being cared for when someone treats her as a helpless incompetent. Was this how Christopher was treating her when he called her physician?

When Christopher suggested that she tell the physician and the group therapist how she felt about the way they had treated her, his words may have given advice, but his communication actually conveyed agreement with Stella's position that she had been unfairly treated.

Stella experienced Christopher's agreement and support through his intervention. However, what could have made this a more powerful therapeutic interaction would have been either for Christopher to directly acknowledge his misgivings about having taken charge and contacted the physician or to explore how Stella came to hear his initial obliqueness as giving her what she wanted—his care and support.

Research on the Efficacy of Supportive-Expressive Therapy

It is only since the 1980s that psychosocial components of the treatment of substance abuse disorders have become the subject of scientific investigation. Most research on the efficacy of psychotherapy for the treatment of substance abuse disorders has concluded that it can be an effective treatment modality (Woody et al., 1994). Comparisons among specific models of therapy have become the focus of much interest.

As mentioned above, SE psychotherapy has been modified for use with methadone-maintained opiate dependents and for cocaine dependents. In SE therapy, the client is helped to identify and talk about core relationship patterns and how they relate to substance abuse. One study compared SE therapy and cognitive–behavioral therapy with standard drug counseling for opiate dependents in a methadone maintenance program. Clients were offered once-weekly therapy for 6 months. Adding professional psychotherapies (either SE or cognitive–behavioral) to drug counseling benefited clients with higher levels of psychopathology more than using drug counseling alone. However, drug counseling alone was helpful for clients with lower levels of psychopathology (Woody et al., 1983). Another study involving three methadone programs was also positive regarding the efficacy of SE therapy (Woody et al., 1995). In this study, clients receiving SE therapy required less methadone than those who received only standard substance abuse counseling, and after 6 months of treatment these clients maintained their gains or showed continuing improvement. Gains tended to dissipate in those who received drug counseling only (Woody et al., 1995).

One study compared SE psychotherapy with structural family therapy for the treatment of cocaine dependence (Kang et al., 1991; Kleinman et al., 1990). Both types of therapy were offered once a week. The researchers found that once-weekly therapy, of either type, was not associated with significant progress. Dropout rates were high, and overall abstinence in both groups did not appear to differ from that expected from spontaneous remission. The main conclusions were that the lack of treatment effects may have resulted because these treatments did not offer enough frequency and intensity of contact to be effective for cocaine-dependent people in the initial stages of recovery. This study had at least two flaws, however. One was that the therapists were not well-trained in SE therapy; therefore, it is questionable whether or not the treatment they provided was actually SE therapy. The other was that the therapy was provided in a municipal office building where courts and social services were administered, thus this setting lacked many features of traditional substance abuse treatment settings.

More recently, a large multisite study of 487 persons receiving treatment compared SE therapy with cognitive therapy and drug counseling for cocaine dependence (Crits-Christoph et al., 1997). Each of the three conditions included, in addition to the individual treatment, a substance abuse counseling group. A fourth condition received group counseling without additional individual therapy. This study was a theoretical descendant of the methadone studies mentioned earlier. It was hypothesized that SE and cognitive therapy might be more effective than individual drug counseling for clients with higher levels of psychiatric severity. The results showed that each type of treatment was associated with significantly reduced cocaine use. However, for this population of outpatient cocaine-dependent clients, drug counseling was more successful at reducing substance use than SE or cognitive therapy (Crits-Christoph et al., 1999). One implication of this finding is that drug-focused interventions are perhaps the

optimal approach for providing treatment for substance abuse disorders (Strean, 1994).

What this means for practitioners of psychodynamically oriented treatments is that in addition to providing the more dynamic interventions, it is important to also incorporate direct, drug-focused interventions. This can be accomplished by one therapist combining both models or, in a comprehensive treatment program for substance users, one therapist providing dynamic therapy and an alcohol and drug counselor providing direct, drug-focused counseling. It can be argued that this is why SE therapy was so helpful in the methadone studies. In those studies, psychodynamic therapy was well integrated into a comprehensive methadone maintenance program. In other words, in addition to the dynamic therapy, clients received substance abuse disorder counseling along with methadone (Woody et al, 1998).

One study conducted a small, controlled trial comparing SE therapy to a brief (one-session) intervention for marijuana dependence. The SE approach was adapted for use in treatment of cannabis dependence (Grenyer et al., 1995) and was offered once a week for 16 weeks. Results showed that both interventions were helpful but SE therapy produced significantly larger reductions in cannabis use, depression, and anxiety, and increases in psychological health (Grenyer et al., 1996). The authors concluded that SE therapy could be an effective treatment for cannabis dependence.

Clients Most Suitable for Psychodynamic Therapy

Brief psychodynamic therapy is more appropriate for some types of clients with substance abuse disorders than others. For some, psychodynamic therapy is best undertaken when they are well along in recovery and receptive to a higher level of self-knowledge.

Although there is some disagreement in the details, this type of brief therapy is generally thought more suitable for the following types of clients:

- Those who have coexisting psychopathology with their substance abuse disorder
- Those who do not need or who have completed inpatient hospitalization or detoxification
- Those whose recovery is stable
- Those who do not have organic brain damage or other limitations due to their mental capacity

Psychodynamic Concepts Useful in Substance Abuse Treatment

Psychodynamic theories endeavor to provide coherent explanations for intrapsychic and interpersonal workings. Because of the importance of this approach in the development of modern therapy, the techniques that stem from these theories are inevitably used in any type of psychotherapy, whether or not it is identified as "psychodynamic." For example, people who have worked with those who have substance abuse disorders are familiar with "denial," even if they are not aware that this process is one of the psychodynamic defense mechanisms. Counselors whose clients have an immediate and strong negative reaction to them often benefit from an understanding of the concept of "transference." It also is helpful for an alcohol and drug counselor who is left feeling hopeless and confused after a session to understand how "countertransference" could be at work. Therefore, counselors who treat clients with substance abuse disorders can benefit from understanding the basic concepts of general psychodynamic theory discussed in this section, even if they do not use a strictly psychodynamic intervention.

The Therapeutic Alliance

The alliance that develops between therapist and client is a very important factor in successful therapeutic outcomes (Luborsky, 1985). This is true regardless of the modality of therapy. The psychodynamic model has always viewed the therapist–client relationship as central and the vehicle through which change occurs. Of all the brief psychotherapies, psychodynamic approaches place the most emphasis on the therapeutic relationship and provide the most explicit and comprehensive explanations of how to use this relationship effectively. Luborsky and colleagues are among those who have documented the profound effect that the therapist–client relationship has on the success of treatment, however brief (Luborsky et al., 1985).

The psychodynamic model offers a systematic explanation of how the therapeutic relationship works and guidelines for how to use it for positive change and growth. In all psychodynamic therapies, the first goal is to establish a "therapeutic alliance" between therapist and client. In most cases, the development of a therapeutic alliance is partially a process of the passage of time. The more severe the client's disorder, the more time it will take. The capabilities of the therapist to be honest and empathic and of the client to be trusting are also factors. A therapeutic alliance requires intimate self-disclosure on the part of the client and an empathic and appropriate response on the part of the therapist. However, in brief psychodynamic therapy this alliance must be established as soon as possible, and therapists conducting this sort of therapy must be able to establish a trusting relationship with their clients in a short time.

One study of the therapeutic alliance and its relationship to alcoholism treatment found that for alcoholic outpatients, ratings of the therapeutic alliance by the patient or therapist were significant predictors of treatment participation and of drinking behavior during treatment and at 12-month followup, though the amount of variance explained was small (Connors et al., 1997). Among cocaine-dependent patients, another study found that patients' ratings of the therapeutic alliance predicted the level of current drug use at 1 month but not at 6 months (Barber et al., 1999). The alliance at 1 month, however, predicted improvement in depressive symptoms at 6 months. These findings suggest that the therapeutic alliance exerts a moderate but significant influence on outcome in the treatment of substance abuse disorders. The specific outcomes measured vary from study to study but include length of participation in treatment, reduction in drug use, and reduction in depressive symptoms.

Developmental Level

Psychodynamic theory emphasizes that the client's level of functioning should determine the nature of any intervention. In Freudian psychoanalytic theory, substance abuse is considered a symptom associated with the oral or most primitive stage of development and represents an attempt to establish a need-gratifying symbiotic state (Leeds and Morgenstern, 1996). Analytic theorists within the Object Relations school hold that substances stand in for the functions usually attributed to the primary maternal (or care-giving) object. As a result, the substance abuser relates to the substance based on the disturbed pattern of relating that he experienced with the maternal object (Krystal, 1977). This would be considered a variant of borderline psychopathology, which is viewed as a fairly severe disturbance of ego functioning and object relations. It is for this reason that substance-abusing clients were and perhaps still are often considered unsuitable for psychoanalysis and also unsuitable for many of the short-term analytic models that involve a

very focused and active uncovering of the unconscious.

Contemporary analytic theorists who concern themselves with substance abuse disorders typically do not focus on the idea that addiction is linked to a developmentally primitive level of ego functioning, although they may endorse it. One reason is that this idea leads to a rather pessimistic belief regarding the outcome of analytic treatments for substance abuse disorders. Another reason is that it does not contribute helpful information to the therapeutic approach, and it can impede the development of an empathic and respectful therapeutic alliance. Furthermore, there is increasing empirical evidence for the idea that severe substance abuse is largely driven by biobehavioral forces and that individual psychological factors are of lesser importance (Babor, 1991). Although analytic theories have tended to ignore this (Leeds and Morgenstern, 1996), it has become increasingly a part of the knowledge base in understanding substance abuse disorders.

Insight

Another critical underlying concept of psychodynamic theory—and one that can be of great benefit to all therapists—is the concept of insight. Psychodynamic approaches regard insight as a particular kind of self-realization or self-knowledge, especially regarding the connections of experiences and conflicts in the past with present perceptions and behavior and the recognition of feelings or motivations that have been repressed. Insight can come through a sudden flash of understanding or from gradual acquisition of self-knowledge. So, for example, a client who feels depressed and angry and subsequently drinks comes to realize that his feelings toward his father are stimulated by an emotionally abusive supervisor at work. This type of realization gives the client new options. These options include learning to separate his reactions to the supervisor from his feelings about his father, working through his feelings about his father (of which he may not have been previously aware), actively choosing alternative behaviors to drinking when he feels bad (e.g., attending a 12-Step meeting), and accepting greater responsibility for his feelings and behaviors.

A broader definition of insight, also promoted by brief psychodynamic therapies, is simply any realization about oneself, one's inner workings, or one's behavior. For example, a client who says, "the only emotion I really feel is anger," has opened the door to understanding the effect others have on her, and vice versa. She can then begin to develop alternative behaviors to those that previously followed automatically from her anger (such as drinking), as well as to understand why her emotional repertoire is so limited.

Insight involves both thoughts and feelings. A purely intellectual exercise will not lead to behavior change. True insight involves a powerful emotional experience as well as a cognitive component and leads to a greater acceptance of responsibility for feelings and behavior. In treating substance abuse disorders, it is important to recognize that insight alone is often not sufficient to create change. Substances of abuse are powerful behavioral reinforcers and the therapist needs to help the client counter the strong compulsive desire for them. Thus, in addition to insight, it could be helpful to offer psychoeducation and make behavioral interventions, which might include encouraging attendance and participation in self-help programs and requiring regular testing by urinalysis and/or Breathalyzer™. Many therapists who conduct substance abuse treatment from a psychodynamic perspective are comfortable combining insight-oriented therapy with concrete, behavioral interventions.

Defense Mechanisms And Resistance

In psychoanalytic theory, defense mechanisms bolster the individual's ego or self. Under the pressure of the excessive anxiety produced by an individual's experience of his environment, the ego is forced to relieve the anxiety by defending itself. The measures it takes to do this are referred to as "defense mechanisms." All defense mechanisms have two characteristics in common: they deny, distort, or falsify reality, and they operate unconsciously. Some defense mechanisms are adaptive and support the mature functioning of the individual, while others are maladaptive and hinder the individual's growth. Generally the defenses hamper the process of exploration in therapy, and for this reason they are often confronted in the more expressive models of analytic therapy. However, in more supportive types of therapy, adaptive defenses are supported, and even the maladaptive defenses may not be confronted until the therapist has enabled the client to replace them with a more constructive means of coping.

In the treatment of substance abuse disorders, defenses are seen as a means of resisting change—changes that inevitably involve eliminating or at least reducing drug use. Mark and colleagues noted that two defenses frequently seen in those with substance abuse disorders are denial and grandiosity (Mark and Luborsky, 1992). Particularly with this group of clients, handling defenses can degenerate into an adversarial interaction, laden with accusations; for example, when a therapist admonishes the client by saying, "You are in denial" (Mark and Luborsky, 1992). They recommend avoiding ineffective adversarial interactions around the client's use of defenses by using the following strategies:

- Working with the client's perceptions of reality rather than arguing
- Asking questions
- Sidestepping rather than confronting defenses
- Demonstrating the denial defense while interacting with the client to show her how it works

Figure 7-1 defines the most common mechanisms clients use to defend themselves from painful feelings or to resist change.

Transference

Effective use of the therapeutic relationship depends on an understanding of transference. Transference is the process of transferring prominent characteristics of unresolved conflicted relationships with significant others onto the therapist. For example, a client whose relationship with his father is deeply conflicted may find himself reacting to the therapist as if he were the client's father. The opening session in psychodynamic therapy usually involves the assessment of transference so that it may be incorporated into the treatment strategy. Strean found that, "all patients—regardless of the setting in which they are being treated, of the therapeutic modality, or the therapist's skills and years of experience—will respond to interventions in terms of the transference" (Strean, 1994, p. 110).

An initial goal of brief psychodynamic therapy is to foster transference by building the therapeutic relationship. Only then can the therapist help the client begin to understand her reasons for abusing substances and to consider alternative, more positive behavior. A longer term goal—necessitated by the brevity of the process—is to increase the client's motivation and participation in other modalities of treatment for substance abuse disorders.

Etiology

Four contemporary analytic theorists have offered valuable psychodynamic perspectives on the etiology of substance abuse disorders.

Wurmser, a traditional drive theorist, suggests that those with substance abuse disorders suffer from overly harsh and destructive superegos that threaten to overwhelm the person with rage and fear. Abusing substances is an attempt to flee from such dangerous affects. These affects are the result of conflict between the ego and superego, brought about by the harshness of the superego. Given this understanding, Wurmser's main focus is the analysis of the superego. He believes that a moralistic stance toward the substance-abusing behavior is counterproductive and that substance abusers' problems consist of too much, rather than too little, superego. Wurmser recommends that the therapist provide a strong emotional presence and a warm, accepting, flexible attitude.

Figure 7-1

Defense Mechanisms

- *Denial*. Pretending that a threatening situation does not exist because the situation is too distressing to cope with. A child comes home, and no one is there. He says to himself, "They are here. I'll find them soon."
- *Displacement*. Feelings and thoughts directed toward one person or object are directed toward another person. For example, an employee has feelings of anger toward his boss but is unaware of these feelings because of his internal conflict over acknowledging them. Instead he becomes disproportionately angry at his wife over a minor problem at home.
- *Grandiosity*. Although not one of the originally identified analytic defenses, grandiosity is frequently employed by substance abusers (Mark and Luborsky, 1992). Grandiosity defends against unconscious low self-esteem by invoking self-deceptive, overly positive opinions about oneself. An example of grandiosity in a substance-abusing client is the client who insists that he can maintain control of drug use despite the fact that he was using an increasingly large amount of drugs with increasing frequency. This example can be seen as denial as well because denial involves denying or minimizing the consequences of the addiction. However, the grandiosity is evident in the user's unrealistic belief that he is in control of his drug use when it would seem that his use is compulsive and clearly out of control at this point.
- *Identification with the aggressor*. The activity of doing unto someone else what aroused anxiety when it was done to oneself. A child has a tonsillectomy. She then puts on a toy stethoscope and goes around pretending to take out the tonsils of her playmates.
- *Introjection*. The individual "takes inside" himself what is threatening. For example, a child feels strong anxiety about losing a parent's love when the latter admonishes her for not cleaning her room. To cope with the anxiety she tells herself, "You are a bad girl."
- *Isolation*. Painful ideas are separated from feelings associated with them. To face the full impact of sexual or aggressive thoughts and feelings, the ideas and affects are kept apart. For example, the thought of shouting obscenities in a church is kept separate from all the rage about being in church. Thus, in isolation the individual may have fleeting thoughts of an aggressive or sexual nature without any emotional accompaniment.
- *Projection*. This is the opposite of introjection; an intolerable idea or feeling is ascribed to someone else. For example, it could be hypothesized that because the late Senator Joseph McCarthy could not tolerate his own homosexual wishes, he spent much time compiling lists of men in the State Department who, according to McCarthy, were hiding their homosexuality.

Figure 7-1 (continued)

Defense Mechanisms

- *Reaction formation.* A painful idea or feeling is replaced by its opposite. A young girl, for example, who cannot tolerate her hateful feelings toward her new baby brother keeps saying, "I love my new brother!"
- *Regression.* A retreat to an earlier form of behavior and psychic organization because of anxiety in the present. For example, under the impact of anxiety stirred up by wishes to masturbate, a teenager returns to an earlier form of behavior and resumes sucking his thumb.
- *Repression.* An attempt to exclude from awareness feelings and thoughts that evoke anxiety. In repression, the feelings and thoughts may have been experienced consciously at one time, or the repressive work may have stopped ideas and feelings from ever reaching consciousness. For example, an individual may have consciously experienced hateful feelings toward a parent or sibling but, because of the anxiety evoked, blocked the feelings from awareness. Or to protect herself from feeling the unpleasantness and dread of hate and anger, a woman never allows any hostile thoughts or feelings to reach consciousness.
- *Undoing.* Trying to remove an offensive act, either by pretending it was not done or by atoning for it. For example, a boss hates an employee and wishes to fire him. Instead he promotes the employee, thereby diminishing in his mind what he thinks he has done.

Adapted from: Strean, 1994, pp. 13–15.

Khantzian theorizes that deficits, rather than conflicts, underlie the problems of those with substance abuse disorders. That is, weakness or inadequacies in the ego or self are at the root of the problem. Khantzian and colleagues developed Modified Dynamic Group Therapy (MDGT) to address these issues in a group therapy format, and this approach has some empirical support. Khantzian put forth the self-medication hypothesis, which essentially states that substance abusers will use substances in an attempt to medicate specific distressing psychiatric symptoms (Khantzian, 1985). It follows, then, that substance-dependent persons will express a strong preference for a particular drug of choice to medicate their particular set of symptoms. For example, those dependent on opioids are thought to be medicating intense anger and aggression that their egos are unable to contain. Cocaine-dependent people are believed to be seeking relief from intense depression or emotional lability (as in bipolar disorders) or attention deficit disorder. This continues to be a popular theory although most researchers and therapists now would say that this can offer only partial answers to the questions of how abusers develop drug preferences and what the meaning is of such preferences. It is important to consider the social and physical environmental context of substance abuse as well. That is, whatever drugs are most readily available in a person's community and what his peers and associates are using also have a strong influence on a user's drug preference.

Krystal offers two possible theories of the etiology of substance abuse disorders. One is based on an object-relations conceptualization. In this theory, the substance abuser experiences the substance as the primary maternal object. The substance abuser relates to the substance in the same maladaptive relationship patterns that she experienced developmentally with the mother. The second theory focuses on the substance abuser's disturbed affective functions, known as *alexithymia*. It is thought that

individuals with alexithymia do not recognize the cognitive aspects of feeling states. Instead, they experience an uncomfortable, global state of tension in response to all affective stimuli. Thus they seek to relieve this discomfort with substances.

McDougall views substance abuse as a psychosomatic disorder. It is a way of dealing with distress that involves externalizing and making physical what is essentially a psychological disturbance. Substance abuse then is the habitual use of an externalizing defense against painful or dangerous affects. McDougall suggests that these painful affects are the response to deep uncertainty about one's right to exist, one's right to a separate identity, and one's right to have control over one's body limits and behavior. The abuse of drugs is part of a "false self" that the individual creates to ward off these painful feelings.

Some critics have argued that a major limitation of those psychoanalytic theories is that they do not make allowances for the biological bases of substance abuse disorders (Babor, 1991). However, contemporary psychoanalytic theorists acknowledge that biology plays a role in behaviors related to substance abuse. But the unanswered question remains whether biological or psychological factors come first: Why does a person *start* using substances? Analytic concepts are useful here, in that they can be said to facilitate the resolution of problems that contribute to emotional distress and to help explore the connection among interpersonal patterns, emotions, and substance abuse.

Levenson and colleagues offer such a theory (Levenson et al., 1997). They describe a biopsychosocial conceptualization of substance abuse disorders that can, in part, be addressed by brief psychodynamic therapy. In this model, substance abuse disorders are particularly difficult to treat because, unlike other psychological disorders, there is a "primary urge" to abuse substances—an urge that can take precedence over every other aspect of life. Furthermore, the symptom (substance abuse) is often considered pleasurable by the client, in contrast to the symptoms of other psychological disorders (such as anxiety or depression). Thus, "[psychodynamic] therapy should be considered as part of an overall treatment plan that includes some kind of drug counseling and possibly other interventions as well, such as medications and family therapy" (Levenson et al., 1997, p. 125).

Integrating Psychodynamic Concepts Into Substance Abuse Treatment

Many of the concepts and principles used in psychodynamic therapy with clients who have substance abuse disorders are similar to those used with clients who have other psychiatric disorders. However, most therapists agree that people with substance abuse disorders comprise a special population—one that often requires more structure and a combined treatment approach if treatment is to be successful. To effectively treat these clients, it is important to combine skill in the provision of the model of therapy with knowledge of the general factors in the treatment of substance abuse disorders. These include knowledge of the pharmacology and the intoxication and withdrawal effects of drugs, familiarity with the subculture of substance abuse and with substance-dependent lifestyles, and knowledge of self-help programs. It also helps to feel comfortable working with substance abusers and for one's therapeutic style to express acceptance of and empathy for the client. In modifying SE psychotherapy for use with clients with substance abuse disorders, Luborsky and colleagues identified certain emphases that are particularly important (Luborsky et al., 1977, 1989). These emphases, listed below, are relevant for applying other

types of psychotherapy to substance-dependent clients as well.

- Much of the therapist's time and energy are required to introduce and engage the client in treatment.
- The treatment goals must be formulated early and kept in sight.
- The therapist must pay careful attention to developing a good therapeutic alliance and supporting the client.
- The therapist must stay abreast of the client's compliance with the overall treatment program (if the client is involved in a comprehensive treatment program). This includes such things as the client's attendance at all facets of the program, submission to regular urinalysis, and use of any drugs.
- If the client is receiving substitution therapy, such as methadone maintenance, attention should be given to the time of the client's daily dose and when, in relation to the dosing, the client feels therapy is best conducted.

Therapists whose orientations are not psychodynamic may still find these techniques and approaches useful. Therapists whose approaches are psychodynamic will be more successful if they also have a knowledge of the general factors in the treatment of substance abuse disorders and conduct psychotherapy in a way that complements the full range of services that clients with substance abuse disorders receive in a relatively comprehensive program.

Models of Brief Psychodynamic Therapy

Ten major approaches to short-term psychodynamic psychotherapy are briefly summarized in this section (for more detailed information, see Crits-Christoph and Barber, 1991). These approaches differ depending on the extent to which they use expressive or supportive techniques, focus on acute or chronic problems, have a goal of symptomatic change or personality change, and pay attention to intrapsychic or interpersonal dynamics.

Interpersonal psychotherapy is included because it is one of the important and better researched therapeutic approaches for treating substance abuse disorders. It is considered by some to be a psychodynamic model, but there are conflicting opinions on this. This list is not exhaustive; numerous other, perhaps less well known, approaches or modifications of these approaches are not mentioned. Many of these approaches have developed from clinical experience, and some are not well researched, if they are researched at all. Figure 7-2 summarizes the length of treatment, focus, and major techniques of various models of brief psychodynamic therapy.

Mann's Time-Limited Psychotherapy (TLP)

The goal of treatment in TLP is to diminish as much as possible the client's negative self-image through resolution of the central issue (Mann, 1991). Symptoms are reduced or eliminated as a byproduct of the process. TLP works via two main components of the treatment: the therapist's identification of the central issue and the setting of the termination date at the start of treatment. The central issue is always conceptualized in terms of the client's chronic and presently endured pain, resulting from painful life experiences. This pain is a privately held, affective statement about how the client feels about himself. Change comes about through the identification and exploration of the painful feelings about himself and through the feelings of loss surrounding termination. This model has a set treatment length of 12 sessions and promotes working through of termination issues.

Sifneos' Short-Term Anxiety-Provoking Psychotherapy (STAPP)

STAPP is a focal, goal-oriented psychotherapy that is usually practiced in 12 to 15 sessions and sometimes fewer (Nielsen and Barth, 1991). During the first session, the therapist and client agree on a clear psychodynamic focus, rather like a treatment contract. The foci that respond best to STAPP are unresolved Oedipal conflicts, but loss, separation issues, and grief may also be acceptable. Change comes about through the client's learning to resolve an emotional core problem, essentially problemsolving. Resolving the problem promotes a feeling of well-being and a corresponding positive change in attitude.

Davanloo's Intensive Short-Term Dynamic Psychotherapy (ISTDP)

In ISTDP, therapeutic techniques are used to provoke emotional experiences and, through this, to facilitate corrective emotional experiences or the positive reenactments, in therapy, of past conflictual relationships (Laikin et al., 1991). Change comes about by bringing to consciousness these past unresolved conflicts through intense emotional experiences, reexperiencing them in a more cognitive way, and linking them to current symptoms and problematic interpersonal patterns. Extensive use of analysis of the transference relationship also helps to bring the unresolved conflicts to

Figure 7-2
Brief Psychodynamic Therapy

Therapy (Theorist)	Length of Treatment	Focus	Major Techniques
Time-Limited Psychotherapy (Mann)	12 sessions	Central issue related to conflict about loss (lifelong source of pain, attempts to master it, and conclusions drawn from it regarding the client's self-image)	■ Formulation, presentation, and interpretations of the central issue ■ Interpretation around earlier losses ■ Termination
Short-Term Anxiety-Provoking Psychotherapy (Nielsen and Barth)	Usually 12 to 15 sessions	Unresolved conflict defined during the evaluation	■ Early transference interpretation ■ Confrontation/clarification/interpretations
Intensive Short-Term Dynamic Psychotherapy (Laikin, Winston, and McCullough)	5 to 30 sessions; up to 40 sessions for severe personality disorders	Experiencing and linking interpersonal conflicts with impulses, feelings, defenses, and anxiety	■ Relentless confrontation of defenses ■ Early transference interpretation ■ Analysis of character defenses
SE Therapy (Luborsky and Mark)	16 for major depression, 36 for cocaine dependence	Focus on the core conflictual relationship theme	■ Supportive: creating therapeutic alliance through sympathetic listening ■ Expressive: formulating and interpreting the CCRT; relating symptoms to the CCRT and explaining them as coping attempts

Figure 7-2 (continued)
Brief Psychodynamic Therapy

Therapy (Theorist)	Length of Treatment	Focus	Major Techniques
Vanderbilt Time-Limited Dynamic Psychotherapy (Binder and Strupp)	25 to 30 sessions	Change in interpersonal functioning, especially change in cyclical maladaptive patterns	■ Transference analysis within an interpersonal framework ■ Recognition, interpretation of the cyclical maladaptive pattern and fantasies associated with it
Brief Adaptive Psychotherapy (Pollack, Flegenheimer, and Winston)	Up to 40 sessions	Maladaptive and inflexible personality traits and emotions and cognitive functioning, especially in the interpersonal domain	■ Maintenance of focus ■ Interpretation of the transference ■ Recognition, challenge, interpretations, and resolution of early resistance ■ High level of therapist activity
Dynamic Supportive Psychotherapy (Pinsker, Rosenthal, and McCullough)	Up to 40 sessions	Increase self-esteem, adaptive skills, and ego functions	■ Self-esteem boosters: reassurance, praise, encouragement ■ Reduction of anxiety ■ Respect adaptive defenses, challenge maladaptive ones ■ Clarifications, reflections, interpretations ■ Rationalizations, reframing, advice ■ Modeling, anticipation, and rehearsal
Self Psychology (Baker)	12 to 30 sessions, not rigidly adhered to	Change intrapsychic patterns. Incorporate more diverse representations of others and changes in information processing	■ Analysis of the mirroring, idealizing, and merger transferences ■ Supportive, empathic
Interpersonal Psychotherapy (Klerman)	Time limited; for substance abuse, the trials have been 3 and 6 months	Eliminating or reducing the primary symptom; improvement in handling current interpersonal problem areas, particularly those associated with substance abuse	■ Exploration, clarification, encouragement of affect, analysis of communication, use of the therapeutic relationship and behavior-change techniques

Sources: Crits-Christoph and Barber, 1991; Klerman and Weissman, 1993; Rounsaville and Carroll, 1993.

the client's consciousness so that they can then be explored and resolved.

SE Psychoanalytic Psychotherapy

This model of dynamic therapy can be offered as an open-ended or a time-limited approach (Luborsky, 1984; Luborsky and Mark, 1991). The term "supportive" refers to the techniques aimed at directly maintaining the client's level of functioning—that is, "supporting" the client. The term "expressive" refers to techniques that intend to facilitate the client's expression of problems and conflicts and their understanding. Therapists using this approach will

- Develop a good therapeutic alliance
- Formulate and respond to central relationship patterns
- Understand and respond to how the symptom fits into the central relationship pattern
- Attend to and respond to concerns about separation (therapy termination)
- Make interpretations that are appropriate to the client's level of awareness
- Recognize the client's need to test the therapeutic relationship (in transference terms)
- Frame the symptoms as problem-solving or coping attempts

Change comes about through three curative factors: a positive helping relationship, gains in self-understanding, and internalization of these gains.

The Vanderbilt Approach to Time-Limited Dynamic Psychotherapy (TLDP)

The primary goal of this therapy is to foster positive change in interpersonal functioning, which will then have beneficial effects on the more circumscribed symptoms (Binder and Strupp, 1991). Interpersonal problems are conceptualized in a specific format termed the "cyclical maladaptive pattern," which includes four categories of information:

- Acts of the self toward others
- Expectations about others' reactions
- Acts of others toward the self
- Acts of the self toward the self (introjection)

The theory of change is that therapy is a set of interpersonal transactions through which the client learns and is then able to change the maladaptive interpersonal patterns in her life. Analysis of the transference relationship and the therapeutic relationship as a model for healthier relationships are important components of the therapy.

Short-Term Dynamic Therapy of Stress Response Syndromes

This approach to brief dynamic therapy was developed for use with clients who are dealing with recent stressful events, such as traumatic experiences or the death of a loved one (Horowitz, 1991). The therapist establishes a working alliance with the client and then, using techniques appropriate to the client's state of mind and control processes, helps the client to integrate the life event and its meaning into his schema (a schema is one's way of understanding oneself in relation to others). The therapist fosters this process of integration and understanding by focusing attention, correcting distortions, making linkages, and counteracting defensive avoidance. For research, this model is offered as a 12-session therapy, but it can also be used as an open-ended therapy in clinical practice.

Brief Adaptive Psychotherapy (BAP)

BAP is a short-term analytic model developed to treat clients with personality disorders, although it is applicable to other groups of clients as well (Pollack et al., 1991). The theory of change is that through cognitive and affective

understanding of the origins and operations of the maladaptive pattern, the client can change and construct more adaptive patterns. The techniques used include maintenance of a focus, much work on transference, and a high level of activity on the part of the therapist. The major maladaptive pattern is an interpersonal pattern, and it is explored in the present, in the past, and in the client-therapist relationship. These three areas are repeatedly linked to one another. The maximum number of sessions offered is 40, which Pollack and colleagues point out is more than some of the other brief models because of the higher level of psychopathology of the clients.

Dynamic Supportive Psychotherapy

Supportive therapy is widely practiced clinically but historically is defined mainly by the absence of expressive or interpretive components of psychoanalytic therapies (Pinsker et al., 1991). It evolved as the psychodynamically based therapy used for lower functioning or more fragile clients for whom the expressive work of therapy might be too distressing. The therapist has a cohesive psychodynamic formulation of the client but only shares parts of it in a manner intended to foster the client's adaptive functioning. The goals of supportive therapy are to ameliorate symptoms and to maintain, restore, or improve self-esteem, adaptive skills, and ego function. Change comes about from learning and from identification with or introjection of an accepting therapist with whom the client has a good relationship. The techniques used include reducing anxiety, respecting defenses, clarification, limiting confrontation and interpretation, enhancing self-esteem, reframing, offering encouragement, advising, and modeling.

A Self-Psychological Approach

The essential aspects of the theory of Self Psychology (Baker, 1991) include the following:

- Empathy
- The concept of the selfobject
- The importance of the self in motivating behavior
- The role of symptoms as the client's way of restoring self-cohesion

In this brief self-psychological therapy approach, one or two goals are established collaboratively in the initial sessions. The duration of treatment typically is 20 to 30 sessions, with fewer or more as needed. A selfobject is something or someone else that is experienced and used as if it were part of one's own self (Baker, 1991). For example, a child is dependent on the parent's love and praise to develop a sense of self-worth and self-esteem. In that way, the child internalizes a part of the parent as the selfobject. The theory of change is that understanding, followed by interpretation, leads to change. Success in therapy requires that dysfunctional intrapsychic structures be changed and/or that compensating new structures be added.

Interpersonal Psychotherapy (IPT)

IPT was developed initially as a time-limited, weekly psychotherapy for nonbipolar, nonpsychotic, depressed clients (Klerman et al., 1984). It has since been summarized in a manual for research and modified for treatment of other types of depression (dysthymia), other populations (adolescents and couples), and other problems (substance abuse disorders and bulimia). The goals of this approach are primarily symptom reduction and improvement in interpersonal functioning. The main techniques include the following:

- The problem is explicitly diagnosed and the client is given the "sick" role.
- The client is educated about the problem, its causes, and the treatments available.
- The interpersonal context of the problem and its development are identified.

- Strategies for dealing with the interpersonal context emerge and are tried by the client (problemsolving).

Other Research

In addition to Supportive-Expressive psychotherapy, both IPT and MGDT have been studied as therapies for use in the treatment of substance abuse disorders.

IPT has been evaluated as an adjunctive treatment for a full-service methadone clinic (Rounsaville et al., 1983). This was a collaborative research project that paralleled a study by Woody and colleagues (Woody et al., 1983). Seventy-two methadone-maintained, opiate-dependent subjects who were diagnosed with a psychiatric disorder (e.g., depression) were randomly assigned to one of two treatment conditions, each lasting 6 months. The treatments were IPT offered once a week and low contact, consisting of one 20-minute meeting per month, when symptoms and social functioning were reviewed. Both groups also received treatment as usual in the methadone-maintenance program that included a weekly 90-minute session of group counseling. The main findings were that it was extremely difficult to recruit and retain clients in the program and that although both treatments were associated with significant clinical improvements during the 6-month period, there was essentially no advantage to IPT over low contact. This study was done in a program in which clients were suspended after 3 months if they continued to use illicit drugs, thus providing a potent behavioral intervention. For the control group, clients were forced to do well or leave the program.

A second study (Carroll et al., 1991) compared IPT with Relapse Prevention (RP), a cognitive–behavioral therapy (Marlatt and Gordon, 1985) for the treatment of ambulatory cocaine-using clients. This study evaluated the efficacy of 12 sessions of weekly individual psychotherapy, without adjunctive pharmacotherapy, as the sole treatment for 42 subjects who were randomly assigned to either IPT or RP. Rates of attrition were significantly higher for IPT than for RP, with only 38 percent of those in IPT compared to 66 percent of those in RP completing the 12-week course of treatment (Rounsaville and Carroll, 1993). On most outcome measures there were no significant differences between the two treatment conditions; both were associated with favorable outcomes. However, for clients with more severe psychiatric symptoms or more severe drug use, those who received RP were more likely to become abstinent than those who received IPT. Clients with more severe substance abuse disorders may require the greater structure and direction offered by the relapse prevention approach (Rounsaville and Carroll, 1993). This is entirely consistent with the observation that substance-focused interventions are perhaps the optimal approach for treating substance abuse disorders (Strain, 1999). Based on the rather modest empirical support, Rounsaville and Carroll suggested that the role of IPT in the treatment of substance abuse disorders might be the following:

- To introduce clients into treatment
- To treat clients with lower levels of substance abuse
- To treat clients who did not benefit from other modalities
- To complement other ongoing treatment modalities
- To help clients maintain and solidify gains following the establishment of stable abstinence

Khantzian and colleagues developed MGDT to address the characterological underpinnings of substance abuse disorders (Khantzian et al., 1990). The group has four main goals:

1. The development of affect tolerance
2. The building of self-esteem
3. The discussion and improvement of interpersonal relationships
4. The development of appropriate self-care strategies

This approach has shown efficacy for abuse in research, but the research was not comparative, so it is not known how effective this approach is in contrast to other approaches.

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8 Brief Family Therapy

Substance abuse disorders do not develop in isolation. For many individuals with substance abuse disorders, interactions with the family of origin, as well as the current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is suggested when the client exhibits signs that substance abuse is strongly influenced by family members' behaviors or communications with them. Family therapy might be contraindicated if other family members are active substance abusers, violent, deny that the client's substance abuse is problematic, or remain excessively angry.

Family therapy is often used to examine factors that maintain a client's substance abuse behavior. To understand these factors, the therapist considers the family's various structural elements and how they contribute to the substance abuse. These elements might include the power hierarchy, roles, rules, alignments, and communication patterns within the family. Through family therapy, the clinician can help the family identify dysfunctional areas, adjust its hierarchy, change various roles that members play, change dysfunctional rules, alter dysfunctional alignments between family members, and replace dysfunctional communications with clear, direct, and effective communication.

Family involvement is often critical for success in treating many substance abuse disorders—most obviously in cases where elements of the family are inadvertently reinforcing or supporting the problem. In some cases, another family member has a different agenda from the rest of the family. For example, the husband of a recovering substance abuser may have taken on additional roles in the family as a result of the vacuum left when his wife was abusing substances. The husband may be unwilling to let her resume her place in the family or share control of the family budget, for example. Unless family therapy can shift his position, the client's recovery is likely to be impeded. When the whole family is involved in therapy, changes are faster and easier to maintain. In addition, the client gains a built-in support system.

Complex interactions between family dynamics and substance abuse have long been recognized (Lewis, 1937). Whalen suggested spousal psychopathology was a contributing factor in the onset and maintenance of substance abuse (Whalen, 1953). Jackson argued on the basis of interviews with members of Al-Anon that the depression, anxiety, and distress seen so often in family members of substance abusers stem from, rather than cause substance abuse disorders (Jackson, 1954).

Contrary to what had long been the popular opinion, most individuals with substance abuse disorders maintain close ties with their families.

Research has consistently shown that people with substance abuse disorders are in closer contact with their families of origin than the members of the general population of comparable age (Bekir et al., 1993; Douglas, 1987).

A number of reviews have found strong support for the use of family therapy methods for substance abuse treatment. Recent research even suggests that family and marital treatment produces better marital and drinking outcomes than nonfamily methods (Lowinson et al., 1997). At least one study that compared long-term and short-term family therapy (16 and 8 casework interventions over an 8- and a 4-month period, respectively) found that shorter services were often more beneficial (Garvin et al., 1976). However, comparable studies specifically on family therapy as applied to substance abuse disorders are lacking.

The Harvard Medical School Department of Psychiatry successfully used couples counseling in the context of treatment for alcohol-dependent clients. Studies of participants in the Harvard Counseling for Alcoholics' Marriages Project (Project CALM) showed that more than 50 percent of husbands with alcohol abuse disorders who participated remained alcohol free in the first year after treatment, compared with less than 30 percent of husbands treated in individual therapy. Participants in the program also had fewer marital separations. With the addition of a relapse prevention program, the results improved even further (Rotunda and O'Farrell, 1997).

Family therapy should be conducted by a clinician with a good understanding of family systems, dysfunctional family patterns, power struggles, and communication. Alcohol and drug counselors can learn to work with families, especially if they do not hold the family responsible for the substance abuse.

If possible, an appropriately trained family therapist should be available to conduct sessions involving a client's family.

Appropriateness of Brief Family Therapy

Long-term family therapy is not usually necessary within the context of treatment for substance abuse disorders. An exception is long-term residential treatment, during which the involvement of the client's family is highly recommended and often is an integral part of the therapeutic process. Making real progress with a family over a long period is challenging. Stumbling blocks, barriers, and pathology seem to emerge. Family members drop out and reenter the therapeutic process, and it becomes increasingly difficult for the therapist to avoid making decisions. The family may try to incorporate the therapist into the family system, routinely seeking direction in a crisis. Boundary and projection issues must be addressed. In short-term family therapy, the boundary between the therapist and the family is more clear. In general, it is easier to continue to help an individual work within the family system through subsequent individual therapy.

Some traditional approaches encourage clients to work on themselves in isolation from others, but there are very few instances in which the opportunity to work with a client's family—for at least one or a few sessions—is not beneficial. Obviously, one such exception is when the client is unwilling to pursue this approach. Another instance best dealt with individually is when the client's situation involves issues of separation and individuation although conjoint family work often helps complete this process. Physical, emotional, or sexual abuse of the client by a family member may also rule out family therapy. Short-term

family therapy is an option that could be used in the following circumstances:

- When resolving a specific problem in the family and working toward a solution
- When the therapeutic goals do not require in-depth, multigenerational family history, but rather a focus on present interactions
- When the family as a whole can benefit from teaching and communication to better understand some aspect of the substance abuse disorder

Family therapy offers an opportunity to

- Focus on the expectation of change within the family (which may involve multiple adjustments)
- Test new patterns of behavior
- Teach how a family system works, and how the family supports symptoms and maintains needed roles
- Elicit the strengths of every family member
- Explore the meaning of substance abuse within the family

An obvious prerequisite for family therapy would seem to be the existence of a family. However, some therapists, including Haley, believe it is possible to "create" a family by drawing on the client's network of significant contacts. A more important question than whether the client is living with a family is, "Can the client's problem be seen as having a relational component (that is, involving two or more people)?" Rather than simply trying to identify existent family members, therapists can begin by conducting an assessment of the client's social network that would include significant others, friends, employers, and coworkers. These people are significant and helpful in the client's life and can be important elements of a client's recovery program.

The definition of "family" also varies in different cultures and situations. For example, for a substance abuser in a Native American group, the notion of family may extend to community members, including healers or others who can help promote or block change. Young children, although not the most powerful members of the family, often have helpful perceptions to contribute to the therapy process. In determining how and when to include children, it is important to consider their age and the nature of the subject matter the family will address. Parental sexual relations, obviously, should be discussed by the parents alone.

Family therapy approaches have been employed with a variety of specific substance-abusing subpopulations, including those who are dually diagnosed (Read et al., 1993; Reilly, 1991; Ryglewicz, 1991), Vietnam veterans with substance abuse disorders and posttraumatic stress disorder (Fahnestock, 1993; Moyer, 1988), older adults with substance abuse disorders (Amodeo, 1990; Crawley, 1993; Rathbone-McCuan and Hedlund, 1989), cocaine abusers (O'Malley and Kosten, 1988; Rice-Licare and Delaney-McLoughlin, 1990; Smokowski and Wodarski, 1996), HIV-positive clients with substance abuse disorders (Barth et al., 1993), and substance-abusing perpetrators of domestic violence (Flanzer, 1989; O'Sullivan, 1989).

Definitions of "Family"

The term "family therapy" evokes images of parents and children. However, as mentioned above, family therapy can involve a network beyond the immediate family, may involve only one family member in treatment or a few members of the family system, or may even include several families at once.

Network therapy views substance abuse disorders from a cognitive–behavioral perspective (Galanter, 1993; Galanter et al., 1997; Keller et al., 1997). In network therapy, significant nonfamily members, such as friends, extended family members, cousins, and grandparents, as well as family members, are

regarded as useful resources available to assist the client.

In contrast, some types of *family systems therapy* regard substance abuse as a symptom of an underlying pathology at work in the family. This approach seeks to restructure the family and the maladaptive behaviors which contribute to (or encourage) the client's substance abuse (Keller et al., 1997).

Conjoint couples therapy addresses couples issues within the family (Epstein and McCrady, 1998; Zweben et al., 1988). Typically, couples carry out assignments in dealing with key therapeutic themes, such as listing the factors that attracted each partner to the other, discussing how the relationship could regain that attraction, and looking at expectations of each partner, needs from the other partner, and resentments. Couples may need to explore their ideas about gender roles within the relationship, or they may have to explore their views on parenting, especially in regard to the disciplining of children. They may also be asked to share ways in which they communicate dissatisfaction or negative feelings about the ongoing substance abuse.

Multifamily groups are often used in substance abuse treatment for educational purposes and as support groups. They can explore ways to attain strategic objectives relevant to each family, offer an opportunity for sharing knowledge, address boundary and communication issues, and expose participants to new ways of managing challenges. Participants realize they are not alone and are helped to maintain their substance-free lifestyle through learning new coping techniques and ways to stop enabling substance abuse. The therapist can apply the experiences of one family to help another. After one family describes a solution, the therapist may ask another, "Would that work in your family?" This approach can promote accountability for maintaining agreements with less stress than would occur in single-family therapy. Typically, four or five families participate, often achieving meaningful results rapidly (Kaufman and Kaufman, 1979).

This approach helps with boundary setting and reestablishment of the parent–child hierarchy. If a parent is the substance abuser, a family role reversal may have occurred in which the children have taken the parental role and become caretakers. In therapy and recovery, it is important that these boundaries be reclarified and that the correct parent–child hierarchy be reestablished. Not communicating is typical in families undergoing substance abuse treatment. One of the goals must be to reestablish lines of communication.

The disadvantage of this approach is that the families involved may not have much common experience; also, some families feel ashamed in this sort of encounter and are not willing to share their experiences. At times, this approach can lead client families simply to complain to one another, without being motivated to find new solutions. One of the responsibilities of the therapist leading the group is to guide the family in exploring alternatives and choosing among them.

Multiple family therapy offers an opportunity to deal with four concerns for families in which substance abuse has been a problem (Brill, 1981):

1. Inadequate internal family development
2. Family systems and role imbalance
3. Selected socialization variances within the family (i.e., differences in the desire and ability of family members to socialize)
4. Dysfunctional, ineffective family behaviors that maintain the problem

Some researchers believe that multiple family therapy is especially useful for families dealing with substance abuse disorders (Kaufman and Kaufman, 1979). In families where one or more members have a substance

abuse disorder, deterioration in the family system is usually seen. Multiple family therapy allows a quick assessment of the deterioration and stimulates a confrontation and strategy to reverse this process.

Furthermore, it is most useful in residential settings where the family is easily accessible, although it has also been successfully used in outpatient settings. Kaufman and Kaufman also found that it works best with highly motivated and involved clients and

> [R]educes the incidence of premature dropouts, acts as a preventive measure for other family members, builds a subculture that acts as an extended 'good family,' and creates and supports structural family changes that interdict the return of drug abuse (Kaufman and Kaufman, 1979, p. 84).

Theoretical Approaches

Many therapists are unfamiliar with effective ways to utilize supportive family members and significant others when treating substance abuse disorders (Bale, 1993; French, 1987; McCrady, 1991). This may stem in part from reliance on popular concepts drawn from the traditional "family disease" model, in which family members of the substance user are seen as suffering from the disease of "codependency" (Beattie, 1987; Coudert, 1972). Cermak even defines codependency using criteria similar to those used in the *Diagnostic and Statistical Manual for Mental Disorders*, 4th Edition [DSM-IV] (Cermak, 1986). According to Schutt,

> [T]he woman who lives with an alcoholic develops an enabling illness. She constantly stands between the alcoholic and his crises, thus enabling and condoning the further usage of the drug (Schutt, 1985, p. 5).

From this perspective, family members of the person with a substance abuse disorder "enable" the substance abuse to continue and so are thought to need help "detaching" or disengaging from their overresponsible involvement with the substance user (Al-Anon, 1979; Bepko, 1985). As a result, treatment often consists of a referral to Al-Anon and (less frequently) separate therapy groups for family members that exclude the substance user (Frankel, 1992; Friedman, 1990; McCrady, 1989; Regan et al., 1983).

Family systems models, on the other hand, instead of focusing on individual personality disorders, generally regard substance abuse and dependence as symptoms of dysfunctional interpersonal dynamics within the family (Bowen, 1974; Gorad et al., 1971). From this perspective, the substance abuse meets a need on some level for the family as a whole and inadvertently reinforces the substance abuse (Davis et al., 1974; Stanton, 1977). Chafetz and colleagues, for example, cite a family who laughed and joked together while the father was intoxicated during an experimental session in contrast to the same family's rather flat affect during a session when the father was sober (Chafetz et al., 1974). The father's alcohol abuse was seen as having become necessary for this family to express their positive emotions. Based on similar anecdotal evidence, many family treatment approaches have evolved that seek to identify the specific role or family-level "adaptive function" served by substance abuse, with the goal of bolstering interpersonal functioning in this area in order to reduce these secondary gains from substance abuse for the individual and the family (Bepko, 1985; Stanton and Todd, 1982; Steinglass et al., 1977). Several family treatment models are described below.

Strategic family therapy (Haley, 1976) and the related Milan school of family therapy (Selvini-Palazzoli et al., 1978) target the positive interpersonal aspects of substance abuse specifically, acknowledging directly its benefits to the family (e.g., "With your husband unemployed as a result of his drinking, he can be home when the children get out of school"), as well as the negative consequences the family

might face if the substance abuse were to end (Fisch et al., 1982; Haley, 1987). Together with such paradoxical interventions as suggesting the family may not yet be ready to change, these interventions often provoke "spontaneous" growth on the part of the family (Weeks and L'Abate, 1979; Winn, 1995). See Chapter 5 in this TIP for more information on strategic and interactional therapies, which often involve the family directly.

Structural family therapy looks beyond the specific family dynamics around substance abuse disorders to more general imbalances in family relationships that might maintain substance abuse, such as extreme disengagements and inappropriate coalitions between family members, especially across generational lines (Minuchin, 1974). Salvadore Minuchin has had an enormous impact on both the theory and practice of structural family therapy, although many of his concepts have been modified as they have been incorporated into the spectrum of modalities. Minuchin stressed the importance of the hierarchy of power within the family and identifying dysfunctional uses of power (e.g., "scapegoating"). It is important to understand both healthy and dysfunctional roles within the family: alignments, collusions, and communication patterns. These key points are routinely explored in family therapy, although many therapists would not feel comfortable "imposing" their own model of health on a family—an issue that did not trouble Minuchin.

Structural therapists explore current family organization, especially hierarchy and intimacy, while encouraging the family to loosen rules and expectations that might be locking the substance abuser into a dysfunctional role (Minuchin and Fishman, 1981; Stanton, 1977). In one of the earliest applications of family therapy for substance abuse disorders, Stanton and Todd worked successfully with families of young male heroin addicts to reestablish parental authority and define clearer intergenerational boundaries, especially between these men and their mothers (Stanton and Todd, 1982).

Bowenian family therapy (Bowen, 1978) also focuses on family-of-origin emotional attachment patterns and unresolved separation issues to make sense of substance abuse disorders. Instead of working through the parental generation, however, adults and adolescents are helped to differentiate and define themselves as individuals by acknowledging and curtailing their residual emotional entanglements. As a result, substance abuse is no longer needed as a way to deny their family-of-origin attachments (Bowen, 1974).

Contextual family therapy (Boszormenyi-Nagy and Spark, 1973) is another transgenerational family model that has been applied in work with families affected by substance abuse (Flores-Ortiz and Bernal, 1989). This approach emphasizes ethical legacies and unconscious loyalties passed along from one generation to the next. For example, the adolescent substance abuser loyally provides her parents the opportunity to vent unresolved anger left from their own upbringing. Treatment helps clarify the ways these unconscious "ledgers" are passed down from generation to generation, and parents are encouraged to deal with their childhood issues directly instead of acting them out through their own children.

Other family therapy models deemphasize the systemic "function" of the substance abuse or family pathology and concentrate instead on utilizing family strengths and enlisting family members as agents of change to motivate the substance user and provide support for ongoing recovery (Liddle et al., 1992; Meyers et al., 1998; Noel and McCrady, 1993; Sisson and Azrin, 1993). This is particularly the case with multiple family therapy models and family psychoeducational groups (Kaufman and Kaufman, 1979; Kymissis et al., 1995; O'Farrell et al, 1985). Frankel described conducting separate

groups for parents and adolescents (Frankel, 1992). Szapocznik and colleagues also extended the family group model to prevention with families of adolescents at high risk of developing a substance abuse disorder (Szapocznik et al., 1989).

Behavioral marital therapy (BMT) models concentrate on teaching and practicing guidelines for clear communication and conflict resolution, marital enhancement, and substance abuse-specific coping skills such as ways to handle relapse productively. The BMT component was developed as part of the Program for Alcoholic Couples Treatment, a research study that received good empirical support after controlled trials (McCrady, 1989). Forty-five people with alcohol abuse disorders and their spouses were randomly assigned to one of three types of spouse involvement during outpatient treatment (approximately 15 sessions) and then followed over a 2-year period.

The first type of treatment was Minimal Spouse Involvement (MSI), where the spouse attended all sessions but only as an observer. Client and clinician worked together to prepare an inventory of the substance abuser's incentives to change and a functional analysis of the substance abuse behavior utilizing the Time-Line Follow-Back Interview (Sobell et al., 1980) and a Drinking Patterns Questionnaire (Zitter and McCrady, 1993). Drinking-specific interventions geared to the client were then taught, including alcohol refusal skills, learning to self-monitor drinking urges and consumption rates on a daily basis, rearranging contingencies to support abstinence, restructuring irrational cognitions, plus developing alternative relaxation and assertiveness skills (McCrady et al., 1986).

The second of the three treatment types, Alcohol-Focused Spouse Involvement (AFSI), included the same drinking-specific assessments and interventions but also assessed the couple using a modified version (Noel and McCrady, 1993) of the Spouse Behavior Questionnaire (Orford et al., 1975). Spouses were trained using role-playing and rehearsals to reinforce abstinence and decrease any of their behaviors that could trigger renewed alcohol consumption. Spouses were also instructed to let the drinker experience negative consequences from drinking and to be more assertive regarding the impact of the alcohol use.

The third type of treatment included all of the training above, plus a BMT component (McCrady et al., 1986). Each couple's interactional behaviors were initially assessed using the Locke-Wallace Marital Adjustment Test (Locke and Wallace, 1959) and Areas of Change Questionnaire (Birchler and Webb, 1977). Couples in the BMT group were taught ways to enrich their relationship by planning and carrying out shared fun activities, designating special "love days" to demonstrate their affection, and practicing good communications skills with planned family discussions, as well as techniques for problemsolving and negotiation. Finally, to offset the *abstinence violation effect* (a description of which is ih Chapter 4) (Marlatt, 1978), couples were coached to regard any relapse that might occur as an opportunity to sharpen their efforts rather than give up. Booster sessions were sometimes scheduled up to 6 months posttreatment (Noel and McCrady, 1993).

Based on followup assessments at 6 months, couples in the BMT group reported better marital satisfaction and relapsed more slowly after treatment than the other two groups. Clients with partners in the BMT group were also more likely than those with "Minimal Spouse Involvement" to complete treatment (McCrady et al., 1986). Eighteen months after treatment, couples who had received BMT reported enjoying greater relationship satisfaction with fewer marital separations.

In addition, the rate of abstinence among the BMT couples had gradually continued to improve after treatment ended rather than dropping off, as occurred with the other two groups in this study and most other substance abuse treatment programs (McCrady et al., 1991). In support of this particular finding, Stout and colleagues reported the same pattern of improvement 2 years after a similar BMT trial with a different sample of 229 clients with alcohol use disorders (O'Farrell and Cowles, 1989).

According to Noel and McCrady, this long-term effectiveness suggests that marital therapy may prevent relapse during early recovery by stabilizing the substance user's interpersonal context (Noel and McCrady, 1993). Similar BMT approaches have recently been successfully employed with male substance abusers and their partners (Fals-Stewart et al., 1996) and applied in relapse prevention (McCrady, 1993) with booster sessions spread out over the following year (O'Farrell et al., 1993). A BMT approach specifically for female substance abusers is also being studied (Wetchler et al., 1993).

Network therapy approaches (Favazza and Thompson, 1984; Galanter, 1993) recognize the potential support from those outside the immediate family, especially in terms of conducting effective substance abuse interventions. Gathering together those who genuinely care about the welfare of the substance abuser, especially friends and extended family members, helps encourage the substance abuser to stop using and remain abstinent. Galanter also points to the importance of the involvement of Alcoholics Anonymous (AA) in network therapy (Galanter, 1993). Similarly, Selekman has involved peer group members in family therapy with adolescent substance users (Selekman, 1991). Piazza and DelValle have developed therapeutic interventions that actively incorporate larger systems available in the community such as churches and schools (Piazza and DelValle, 1992).

The *community reinforcement approach* (CRA) is a brief systemic/family intervention and therapy model that has shown good results through training the significant others, generally spouses, of treatment-resistant clients with alcohol abuse disorders (Hunt and Azrin, 1973; Sisson and Azrin, 1986, 1989). CRA participants learn to encourage sobriety by reinforcing abstinence while allowing the drinker to experience negative consequences from intoxication. Significant others also learn to identify a time when the drinker might be willing to enter treatment, in contrast to the confrontational methods advocated by the Johnson Institute (Johnson, 1986) and Unilateral Family Therapy models (Thomas and Ager, 1993). CRA participants are prepared to contribute to the treatment process when and if the drinker agrees to this. Because domestic violence remains a significant risk throughout this process, spouses and significant others are helped to recognize and respond to warning signs by de-escalating conflict and ensuring their own safety.

Once the drinker agrees to enter treatment, the significant other attends all further sessions and participates in communication-skills training and "reciprocity marriage counseling" to develop mutually reinforcing behaviors (Sisson and Azrin, 1989). The significant other is also asked to monitor the drinker's disulfiram use (Antabuse) on a daily basis and to respond appropriately if the disulfiram is not taken (Sisson and Azrin, 1993). Besides disulfiram and marital counseling, drinkers in the CRA programs receive job and social skills counseling as needed. It is worth noting that some CRA sessions have been held in the family's home (Hunt and Azrin, 1973), recognizing the potential for home-based treatments (Henggeler et al., 1996).

In a study utilizing the CRA approach, 12 significant others of treatment-resistant clients with alcohol abuse disorders were randomly divided to form a CRA group of seven and a control group of five who were referred to Al-Anon. Of the CRA group, six of the seven resistant spouses entered treatment, compared with none of the Al-Anon group partners. The partners of CRA participants reduced their drinking days from 24 per month to 11 before entering treatment, and this rate dropped to 2 drinking days per month once the couple started joint treatment (Sisson and Azrin, 1986). (More information on the CRA model can be found in Chapter 4 of this TIP.)

The CRA has been modified into the *community reinforcement and family training* (CRAFT) procedure (Meyers et al., 1996) with clinical trials under way (Meyers et al., 1998). This brief systemic intervention and therapy model also works through the concerned other to analyze behavior patterns surrounding substance abuse. Substance abuse triggers and consequences are sought, as well as interpersonal cues and positive consequences that support more adaptive, sober behaviors. This analysis can include the Spouse Enabling Inventory or the Spouse Sobriety Influence Inventory (Thomas et al., 1994). The risk of domestic violence is assessed using the Conflict Tactics Scale (Straus, 1979), and strategies, including a safety plan, are developed. Communication skills are an important aspect of this model. The basic rules taught are to be brief, be positive, be specific and clear, label feelings, express understanding for the other's perspective, accept partial responsibility when indicated, and offer to help (Meyers et al., 1998). A treatment setting is also lined up in anticipation that the substance abuser will agree to accept further help at some point.

In one preliminary study of the CRAFT model, 130 significant others of treatment-resistant clients with alcohol abuse disorders were randomly assigned to either the CRAFT program, an Al-Anon-only group, or a Johnson Institute intervention group (Johnson, 1973, 1986). Of the CRAFT participants with alcohol abuse disorders, 67 percent went into treatment, whereas only 13 percent of the Al-Anon group and 23 percent of the Johnson Institute intervention group entered treatment (Meyers et al., 1998).

CRAFT also works with significant others to improve their social and emotional welfare. Significant others are encouraged to decrease stress by taking care of themselves and making changes to enhance their own well-being and positive social supports. Participants in the CRAFT program have reported reductions in anger, anxiety, and depression, regardless of the substance user's treatment status. Although much of the focus of the CRA and CRAFT models centers on getting the substance abuser into treatment, both programs emphasize the importance of ongoing family or couples sessions employing communication skills training and marital reciprocity counseling (Meyers et al., 1998; Sisson and Azrin, 1986).

Family therapy is often applied in the treatment of adolescents with substance abuse disorders, and many specific family therapy models have been developed for this population. These often weave together concepts and techniques from different schools of family therapy. *Multidimensional family therapy* (MDFT) (Liddle et al., 1992) is a brief family therapy model that has demonstrated significant long-term clinical effectiveness in treating adolescent substance abuse and conduct disorders during controlled trials (Schmidt et al., 1996). MDFT integrates structural/strategic family therapy (Stanton, 1981; Todd, 1986) with research findings on adolescent development (Liddle et al., 1992). The MDFT model is designed to enhance a family's ability to buffer adolescents against destructive peer and social influences by nurturing healthy teen

development through supportive rather than strictly authoritarian parent–child relationships. Individual sessions with the adolescent are interspersed with family sessions to allow the therapist an opportunity to form a supportive relationship with the teen and act as an intermediary between parent(s) and child. Besides relationship issues, the MDFT model recognizes the developmental tasks faced by the adolescent, such as learning to manage emotions and impulses, and tries to specifically address them. Therapy sometimes includes representatives of extrafamilial systems such as school and probationary personnel as well as peers.

Recognizing that most substance-abusing teens and their parents are locked in conflict, the MDFT therapist works to find a common ground and create a context where a more trusting relationship can emerge. Adolescents are challenged to identify and articulate their own issues and goals for therapy and to take steps to achieve these. Parents are challenged to listen to their teens and let the parent–child relationship evolve into one of mutual respect, balancing the parental tasks of guidance with support. This involves charging both the adolescent and the parents with responsibility for change while conveying the clear expectation that the family can arrive at this point of reconciliation (Liddle et al., 1992). See TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999b), for more information on family therapy for adolescent substance users.

In a diverse sample of families (approximately 45 percent African-American or Hispanic), 16 sessions of MDFT led 79 percent of the adolescents to reduce their average alcohol and marijuana use from a daily to a weekly basis. In addition, harder substance use dropped from every other month to zero. Of those who reduced their substance use, 30 percent decided on complete abstinence. There was also a reduction in related conduct disorders among 68 percent of the teens with significant improvements seen in school performance (Schmidt et al., 1996). Most remarkably, these positive outcomes remained at followup 1 year later (Liddle and Dakof, 1995). Based on nonparticipant raters who assessed family therapy videotapes, the reductions in substance use were significantly associated with improvements in the parent–adolescent relationship (Schmidt et al., 1996), a primary goal of MDFT (Liddle et al., 1992). Unfortunately, dropout rates using the MDFT treatment model reached 28 percent, and only 69 percent of the parents were assessed as making progress in modifying their parenting styles (Liddle and Dakof, 1994).

The Institute of Medicine (IOM) recommended that brief couples therapy be included as a treatment option for all alcohol-abusing clients, especially for those still experiencing only mild to moderate problems (IOM, 1990). Based on their review of the treatment outcome literature, Edwards and Steinglass reached a similar conclusion:

> The weight of the evidence...seems so strong at this point as to support a recommendation that family involvement, especially inclusion of non-alcoholic family members in the assessment phase of treatment, be built in as a routine component of alcoholism treatment programs (Edwards and Steinglass, 1995, p. 485).

The brief family therapy approaches reviewed above have all shown positive long-term outcomes in controlled clinical trials. Together these approaches demonstrate the potential for brief family therapy in substance abuse treatment.

Using Brief Family Therapies

Involving family members or concerned others in family therapy can have a number of benefits.

The dynamics of the family are already a factor in the client's substance-abusing behavior in a complex and unique relationship. In the same manner, the family can participate in the positive experience of treatment and recovery.

Duration of Therapy and Frequency of Sessions

The majority of family therapy is conducted on a short-term basis, with some exceptions (Object Relations therapy may take years). Sessions may be 1½ to 2 hours in length. The preferred timeline for family therapy is not more than two sessions per week (except in residential settings) to allow time to practice new behaviors and experience change. Duration of therapy could be 6 to 10 sessions, depending on the purpose and goals of the intervention.

In a residential treatment program, family therapy can take place in a variety of ways depending on program design and length of stay. Some programs have "family weeks" in conjunction with individual treatment. Others may require clients to bring in a significant other one to two nights weekly to work together on recovery issues. Adolescent treatment programs sometimes involve the family continuously throughout treatment.

Certain forms of family therapy have been developed to achieve a high impact in a shorter period of time. One noted derivative of multifamily therapy is the Multiple Impact Model developed by Wegscheider-Cruse (1989), who brought together groups of four or five sober individuals who were previously substance dependent and their families for a concentrated, extended weekend of work. The purpose was to enable the families to support the continued sobriety of their formerly substance-dependent members. Family roles were recast so that each family member could take on a different role, such as who would make family financial decisions. New agreements between family members were written out. Permanent changes often resulted with motivated families. Wegscheider-Cruse's work has been replicated in several residential settings and training institutes (e.g., the On-Site and the Sierra Tucson Treatment Centers in Tucson, Arizona).

Opening Session

A typical opening session for a family in which a member has a substance abuse disorder might involve the following:

- The therapist seeks to clarify the nature of the problem and to identify the family's goals. The therapist asks each family member the same sort of open-ended questions typically used in individual therapy. For example:
  - "What you would like to see happen here?"
  - "What would you like to work on?"
  - "What is your goal in coming here?"
  - "How did you get here?"
- The therapist educates the family in what is needed to participate effectively in the therapeutic process and to understand key biosocial issues related to substance abuse.
- The therapist provides feedback to the family on what was said, demonstrating whose goals are similar or different.
- The therapist can then move on to prioritizing directions for change or, if the direction is sufficiently clear, start work. Some therapists ask the family to engage in a "contract" that identifies the direction of therapy and delineates each member's commitment to the process.

Early on, practitioners of different theoretical models will make choices about what they will focus on and how to proceed, for example:

- Therapists who practice solution-focused therapy would devote more time to gathering information and affirming family members at the first session, which would

probably conclude with the assignment of tasks designed to test the possibility of change in areas where change seems feasible.

- Therapists applying Eriksonian therapy, after asking family members what they want, might ask, "How will you know when you get there?" A followup question would be, "Is there any reason you can think of why it would not be okay to get there?" This question tests for resistance and any constraints, such as the possibility of family violence, which could prevent open and honest communication. The therapist would then try to do something about that constraint in order to create safety (an action referred to as an "ecological check").
- Therapists using the Mental Research Institute (MRI) strategic model would examine solutions that have already been attempted because most families with a member struggling with a substance abuse disorder try a variety of solutions that have not worked before formal treatment. The family's solution may be seen as the problem.

Followup

Therapists should plan for followup and support as part of the termination process. Residential programs, for example, can hold support groups run by alumni or counselors that are available weekly for family members who want to attend on a voluntary, as-needed basis. Some practitioners ask the client and family members to call them after 6 months or 1 year for a followup conversation. Depending on the family's needs, the therapist may be able to provide reinforcement without further meetings, or may suggest one or two followup sessions to address emerging issues.

At a minimum, clients should be assured that they can call the therapist when necessary.

Cultural Issues

It is important that a family therapist understand the family's ethnic and cultural background. (See the example in the text box below.) Failure to do so may be partially responsible for the large dropout rate by ethnic minorities after the first therapy session (Soo-Hoo, 1999). To successfully promote change within a family system, the therapist will need the family's permission to share their closely held secrets. The therapist's approach, however, must vary according to the cultural background of the family. Working with a Filipino family recently settled in the United States, one therapist had to request a letter from the family elder in the Philippines in order to allow members to reveal family matters to an outsider. Once the family opened up, however, the therapist was seen as an "elder" and was accorded the respect he needed to promote

Native Americans in Brief Family Therapy

A 26-year-old Native American man sought treatment for his alcohol abuse. In a residential treatment setting, the therapist learned that the client's father was a fanatically religious ex-drinker who tried to force his son to go to church. As a result, the client began drinking heavily on Sunday mornings in order to avoid going to church. The client was torn between a culturally based belief that he should respect his elders and his own desire for independence. The therapist encouraged father and son to express both their resentment and their appreciation of each other in letters read aloud to each other. Through this process, the client began to remember what his father had been like as an alcoholic and saw that he himself was in danger of making the same mistake. This motivated the client to accomplish abstinence and to move out of his father's home in order to establish his own household.

positive change. In another example, a therapist working with a client who belonged to the Southern Baptist fundamentalist movement found that the client was immobilized by the shame that surrounded drinking in her family and the difficulty of talking about it. The client approached the family's minister to help frame the situation so that the family could face the problem together and find a solution. (For more information on family therapy for those from unfamiliar cultures, see McGoldrick et al., 1996; Sue and Sue, 1990.)

The language used to describe dynamics within the family system is charged with specific cultural meaning. For example, if a client belongs to a culture that values lifelong interdependence among family members, the therapist would be ill advised to encourage greater independence from the family. However, the therapist might encourage the client to become more effective within his family and explain ways that would allow some freedom within the cultural parameters of the family.

Ablon (with middle-class Catholic families) and Kaufman and Borders have drawn attention to the importance of ethnic and cultural differences to understand and treat families with substance abuse problems (Ablon, 1980; Kaufman and Borders, 1988). Many substance abuse treatment programs have developed culturally specific family therapy models for Latino families (Flores-Ortiz and Bernal, 1989; Laureano and Poliandro, 1991; Panitz et al., 1983; Szapocznik et al., 1991), African-American families (Aktan et al., 1996; Ziter, 1987), and Native American families (Hill, 1989), among others.

A family therapy approach that has been successful with substance-using Hispanic adolescents combines elements from structural, strategic, and Milan therapies (Szapocznik and Kurtines, 1989; Szapocznik et al., 1988, 1991). This approach focuses considerable effort on overcoming initial resistance to treatment because the process embodies the family's issues around the adolescent's substance use (Santisteban and Szapocznik, 1994; Szapocznik and Kurtines, 1989).

9 Time-Limited Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other. The lessons learned in therapy are practiced in the normal social network. Although efficacy research on group therapy for substance abuse disorder clients has been limited, there is substantial anecdotal and clinical evidence that it can have a dramatic impact on participating clients. In TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT, 1994a), group therapy is cited as the treatment modality of choice for a variety of reasons. In clinical practice, group psychotherapy offers individuals suffering from substance abuse disorders the opportunity to see the progression of abuse and dependency in themselves and in others; it also gives them an opportunity to experience their success and the success of other group members in an atmosphere of support and hopefulness. The curative factors associated with group psychotherapy, defined by Yalom, specifically address such issues as the instillation of hope, the universality experienced by group members as they see themselves in others, the opportunity to develop insight through relationships, and a variety of other concerns specific to the support of substance-abusing clients and their recovery (Yalom, 1995). For many years, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have recognized the importance of breaking the isolation associated with substance abuse, while at the same time connecting individuals with others whose common purpose is to dramatically change their lives through connection and community. From these perspectives, time-limited group psychotherapy offers potent opportunities to maximize the treatment energies of both therapist and client.

Research suggests that most client improvement as a result of group therapy occurs within a brief span of time—typically, 2 or 3 months (Garvin et al., 1976). This research implies that short-term therapy can be as successful as long-term therapy in promoting change. Short-term group therapy should be more goal-oriented, more structured, and more directive than long-term group therapy. Some therapists also believe the experience should be intensified through the use of high-impact techniques such as psychodrama (see discussion later in this chapter).

Appropriateness of Group Therapy

Groups can be extremely beneficial to individuals with substance abuse problems. Levine and Gallogly have noted that groups for alcohol-dependent clients

- Help reduce denial, process ambivalence, and facilitate acceptance of alcohol abuse

Group Effects

One Consensus Panelist recalls a therapy session in which a member arrived, furious and hostile, shouting, "How much longer do I have to do this stupid program? None of it works anyway!" Another group member immediately asked, "So, how does the anger keep things going for you?" In the ensuing conversation, the group learned that the angry member's ex-wife had just sent him a bottle of expensive whiskey with the following note: "Dying to get together again." This revelation, and the supportive group listening that followed, occurred largely without verbal involvement from the therapist.

- Increase motivation for sobriety and other changes
- Treat the emotional conditions that often accompany drinking (e.g., anxiety, depression, hostility)
- Increase the capacity to recognize, anticipate, and cope with situations that may precipitate drinking behavior
- Meet the intense needs of alcohol-dependent clients for social acceptance and support (Levine and Gallogly, 1985)

Many beneficial effects happen more easily in groups than in one-on-one therapy. Group members confront each other, do "reality checks," practice reflective listening, mirror each other, and help each other reframe key issues. Individuals in earlier stages of dependence can witness what later stage experiences are like (and by inference where they could progress if they do not reduce their use). Often, group members can be more effective than the therapist in confronting a participant who is not facing an important issue (e.g., the client who believes she can quit drinking and still smoke marijuana).

Group Therapy Approaches

Several kinds of groups fall under the spectrum of time-limited group therapy. In the broadest sense, two fundamental models help define categories of group interventions: the process-sensitive approach and the directive approach. The *process-sensitive* group approach finds its direction in the traditions of analytical theory and has a significant range of expression. Depending on the theoretical base and leadership style of the facilitator, a process-sensitive group can examine the unconscious processes of the group as a whole, utilizing these energies to help individuals see themselves more clearly and therefore open up the opportunity for change. This "group-as-a-whole" approach is best exemplified by the work of Bion, who sees healing as an extension of the individuals within the group as the group comes to terms with a commonly shared anxiety (Bion, 1961).

Yalom offers a significant contrast to these group-as-a-whole interventions through his interactional group process model (Yalom, 1995). By attending to the relationships within the group and helping individuals understand themselves within the relational framework, an interactional group process provides individuals with significant information about how their behavior affects others and how they are in turn affected by other members. In addition, focusing energy on the relationships within the context of group, the leader is careful not to assume a central role but, rather, recognizes that the group itself becomes the agent of change, with the leader supporting the process but not initiating it. Attention is focused on the nature and growth of the relationships manifested in the "here and now" as the group takes place.

The second approach, and one better known to alcohol and drug counselors, is a dramatically different form of group therapy, often referred to as a *directive approach*. It offers structured goals and therapist-directed interventions to enable individuals to change in desired ways. A short-term directed group may be used to address major issues of concern for clients with substance abuse disorders and to facilitate self-discovery and growth through appropriately sequential activities. Because the therapist is "central" and in charge, this type of group depends less for success on group members and their ability to create a cohesive sense of belonging.

Compared with the process-sensitive group, which sees the cohesive power of the group as a primary curative factor, the directive approach addresses specific agenda items in a logical order with greater emphasis on content as the primary source of effective change. The directive approach, therefore, is perhaps more likely to be effective with those in early recovery. A potent example of directive, time-limited group experience, developed by Maultsby and Ellis, is known as Rational Behavioral Training (RBT) (Maultsby, 1976). This cognitive–behavioral therapy takes place over 13 weeks, one session per week. It uses fundamental cognitive–behavioral interventions and the clients' growing awareness of their ability to control their own belief systems and self-talk and thus control their affective states. Clients are asked to share homework assignments and bring real-life situations into the group for exploration and examination. There is little effort in this group modality to analyze or direct energy to the relationships within the room. RBT affords a short-term intervention to develop the client's skill in controlling emotions. The inference is that individuals who experience their emotional world as controllable will no longer need to use substances to exert "external" control.

It is important to note that in any kind of group therapy, relationships are formed and process issues experienced. Even within the context of a cognitive–behavioral approach such as RBT, which is more educational than therapeutic, issues of process invariably arise. The experienced therapist can use the relationships within the group even in a psychoeducational framework to support and enhance the treatment experience. Whenever the opportunity arises, the group facilitator should help connect members to members. When shared histories are acknowledged, the sense of belonging is increased, and greater cohesion takes place. Cohesion may seem less important in a directive psychoeducational group. However, because of the very nature of substance abuse disorders, a feeling of belonging to a group committed to its own health rather than its own destruction is an important motivator for many clients.

There has been significant debate within the field regarding the pros and cons of heterogeneous and homogeneous groups. The heterogeneous group, in which members have a variety of diagnoses, offers greater complexity and more opportunities for a wide range of relationships, which can be extremely helpful to many clients. However, the homogeneous group, particularly when composed of clients with substance abuse disorders, tends to lend itself more quickly to issues of cohesion and safety. For this reason, homogeneity has particular utility in the time-limited group intervention.

An important issue within the context of the homogeneous substance abuse disorder group, whether time limited or not, is the group's tendency to bond around its history of substance abuse rather than its commitment to recovery. Although the general focus of substance abuse treatment is on the abuse itself, the focus also must include issues of living within the context of the group. Through modeling and gentle

persuasion, the group facilitator can broaden the scope of a substance abuse treatment group to include relationships, concerns about daily living, and newly discovered personal integrity. Such are the struggles of all people in all circumstances. The movement from "what is wrong with us" to "how do we build better lives?" is an important transition in the time-limited group, whether psychoeducational or process sensitive.

Group therapy can be conducted within the context of almost any theoretical framework familiar to the therapist and appropriate to group goals. Often the therapist will work with two or more models at the same time. The theoretical bases supporting both process-sensitive groups and a more directive style can be combined effectively to address substance-abusing clients.

Theories of Group Therapy

The following group therapy models are discussed in this section:

- Brief cognitive group therapy
- Cognitive–behavioral group therapy
- Strategic/interactional therapy
- Brief group humanistic and existential therapies
- Group psychodynamic therapy
- Modified dynamic group therapy (MDGT)
- Modified interactional group process (MIGP)

The first five are summarized below and discussed at greater length in Chapters 4 though 7 of this TIP. MIGP, considered a highly effective type of brief group treatment for substance abusers, is discussed in detail in this section. The 11 therapeutic factors identified by Yalom as the basis of successful group therapy are presented at the end of this section (Yalom, 1995).

Brief Cognitive Group Therapy

Cognitive techniques work well in group therapy. The group is taught the basics of the cognitive approach, then individual members take turns presenting an event or situation that tempted them to abuse substances. Other members assist the therapist in asking for more information about the client's thoughts on the event and how it did or did not lead to substance abuse (or to negative feelings that might have led to use). Finally, the group members provide the client with alternative ways of viewing the situation. Chapter 4 discusses brief cognitive therapy in more depth.

Cognitive–Behavioral Group Therapy

The cognitive–behavioral approach focuses the group's attention on self-defeating beliefs, relying on group members to identify such beliefs in each other. The therapist encourages group members to apply behavioral techniques such as homework and visualization to help participants think, feel, and behave differently. Chapter 4 discusses brief cognitive–behavioral therapy in more depth.

Strategic/Interactional Therapies

The strategic therapist uses techniques similar to those used in family therapy to challenge each group member to examine ineffective attempted solutions. The therapist encourages group members to evaluate and process these attempted solutions and recognize when they are not working, then engages the group in generating alternative solutions. The therapist also works, where appropriate, to change group members' perceptions of problems and help them understand what is happening to them. Typically, the therapist guides the process, while members offer suggestions and encouragement to each other as they identify and implement

effective solutions. To address the problem of substance abuse, the group will often be directed to examine problems that might result in substance abuse and reframe their perceptions of these problems.

The principles of solution-focused therapy are the same for group treatment as for individual therapy. These include client goal-setting through the use of the "miracle" question, use of scaling questions to monitor progress, and identification of successful strategies that work for each client. (These techniques are defined in Chapter 5 of this TIP.) The therapist works to create a group culture and dynamic that encourages and supports group members by affirming their successes. At the same time, the therapist works to restrain client digressions ("war stories") and personal attacks. The therapist tries to challenge group members—all of whom, unlike in family therapy, are seen as "customers"—to take action to create positive change. Chapter 5 discusses brief strategic/interactional therapies in more depth.

Brief Group Humanistic and Existential Therapies

Several approaches fall within this category. The transpersonal approach is useful in meditation, stress reduction, and relaxation therapy groups and can be adapted for clients who have substance abuse disorders. In dealing with issues of religion or spirituality, it is helpful to have other people talk about their perspectives. In this way, past degrading or punitive experiences related to organized religion can be redefined in a more meaningful and useful context.

Gestalt therapy in groups allows for more comprehensive integration in that each group member can provide a piece of shared personal experience. Each group member plays a role in creating the group, and all of their perceptions must be taken into account in making a change. Role-playing and dream analysis in groups are practical and relevant exercises that can help clients come to terms with themselves.

One of the most influential contemporary experts on group therapy, Irvin D. Yalom, considers himself an existentialist because he is not concerned with past behavior except as it influences the "here and now." A summary of his existential approach is presented in *The Yalom Reader* (Yalom, 1997) and consists of three sections: (1) therapeutic factors in group therapy, (2) a description of the "here and now" core concept, and (3) therapy with specialized groups, including a chapter on group therapy and alcoholism. This last chapter details specific techniques to diminish anxiety but still permit the group to maintain an interactional focus—for example, writing a candid summary of the session and mailing it to members before the next meeting. Yalom has worked closely with the National Institute on Alcohol Abuse and Alcoholism to apply basic principles of group therapy to alcohol abusers, and his ideas are applicable to those with other substance abuse disorders as well. See Chapter 6 for more discussion of humanistic and existential therapies.

Group Psychodynamic Therapy

Group psychodynamic therapy enables the group itself to become both the context and means of change through which its members stimulate each other to support, strengthen, or change attitudes, feelings, relationships, thinking, and behavior—with the assistance of the therapist.

> The context sought is one in which the group becomes an influential reference group for the individual. Participation of members according to their abilities leads to some degree of involvement of each in pursuing individual and group goals. The process of goal-setting and clarification for expectation provides an agreed upon framework for meeting of mutual needs. This, in turn,

> contributes to the building of cohesive forces (Roberts and Northen, 1976, p. 141).

Chapter 7 discusses psychodynamic therapy in more depth.

Modified Dynamic Group Therapy

On the basis of psychodynamic theory, a modified dynamic group therapy approach was defined for substance-abusing clients (Khantzian et al., 1990). Viewing substance abuse disorders as an expression of ego dysfunction, affect dysregulation, failure of self-care, and dysfunctional interpersonal relationships, MDGT falls in the intermediate length of time-limited group psychotherapy, with its basic structure defined by two meetings per week over a 26-week format. Based primarily on interventions to address cocaine addicts, MDGT focuses energy on the individuals within the group and conceptualizes the basic origins of substance abuse disorders as expressions of vulnerabilities within the characterological makeup of the client (Khantzian et al., 1990). As a supportive, expressive group experience, MDGT provides substance-abusing clients the opportunity to evaluate and change their vulnerabilities in four primary areas: (1) accessing, tolerating, and regulating feelings; (2) problems with relationships; (3) self-care failures; and (4) self-esteem deficits. Congruent with this understanding of the origins of substance abuse, MDGP emphasizes safety, comfort, and control within the group context. Group facilitation is defined primarily by the therapist's ability to engage and retain substance abusers in treatment by providing structure, continuity, and activity in an empathic atmosphere.

This supportive approach creates an atmosphere of safety, allowing the client to move away from the safety of the known behavior associated with substance abuse and into the less known world of recovery. As in other group experiences, this group theory encourages issues of universality as a means of overcoming isolation, while at the same time dealing with a common shame so often encountered in the substance-abusing client. Unlike interpersonally focused process groups, which look more at relational concerns, MDGT places greater emphasis on the clients' growing understanding of their characterological difficulties and/or deficits, not entirely dissimilar to issues identified in self-help groups such as AA and NA.

Modified Interactional Group Process

Time-limited MIGP is a synthesis of the work of several theorists (Flores, 1988; Khantzian et al., 1990; MacKenzie, 1990; Yalom, 1995). MIGP is distinguished in a variety of ways from the psychoeducational groups so important in substance abuse treatment. As referenced in TIP 8, *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* (CSAT, 1994a), both process-sensitive and psychoeducational group learning experiences are often necessary for the substance-abusing client. Even in a short-term, intensive treatment experience, combining a psychoeducational group and a process group has significant clinical impact. The psychoeducational group is more directive, with the therapist as the central figure. However, as will be explained, it is important to utilize the energy of group process itself, even in a psychoeducational format, to enable clients to make connections and build relationships that will support their recovery.

The features that distinguish MIGP from a more traditional interactive process are the greater activity of the leader and the sensitivity to the development of a safe atmosphere that allows group members to examine relational issues without excessive emotional contagion. The atmosphere of safety is greatly enhanced by the therapist's adherence to group agreements or group norms and by the continued

reinforcement of these agreements throughout the group process. The importance of confidentiality, the group's accepting responsibility for itself, and self-disclosure are all supported by the facilitator. Procedural agreements, including beginning and ending the group session on time and ensuring that each member has a place within the circle, with any absences addressed, are part of the development of the safe environment.

In this process, the therapist helps the clients recognize that they are the primary change agents. The group becomes a safe place both to give and to receive support. Although traditionally substance abuse groups tend to be confrontative, MIGP is far more supportive. This stems from the belief that denial and other defense mechanisms become more rigid when a person is attacked. Consequently, group members are encouraged to support one another and look for areas of commonality rather than use more shame-based interactive styles that attempt to "break through denial."

Intellectualization and MIGP

Many therapists are told that clients should get in touch with their feelings and experience "what is in their gut." Although awareness of the affective life is important to everyone, it is precisely the regulation of emotions that many substance-abusing clients have difficulty addressing. Consequently, although emotional exploration is encouraged within the context of MIGP, the facilitator is constantly monitoring the affective energy within the group, taking steps to break emotional contagion should it begin. In a particularly intense group experience, the therapist may ask the group as a whole to take a step back and look at what just took place. In this way, the group not only learns from its shared life but also experiences its ability to control intense emotional responses. This consistent effort to reduce high levels of anxiety or emotional catharsis and to prevent them from dominating the group is another hallmark of MIGP.

General issues in MIGP

Following the insights of Flores and Mahon, MIGP focuses special attention in four areas of the client's life: gratification and support, vulnerability of self, regulation of affect, and self-care (Flores and Mahon, 1993). These four areas receive particular attention because they represent areas of vulnerability within the substance-abusing client that can easily lead to relapse and undermine recovery.

Gratification and support

Many clients come to treatment with profound issues of guilt and shame. Therefore, they lack the ability to give themselves gratification and support in the face of change. The active leadership style of MIGP allows group members to openly support one another and at the same time provides each group member with attention from the leader that leads to higher levels of gratification. Affirming group members' willingness to share and support one another is an essential ingredient in time-limited group work. It creates a positive atmosphere and increases levels of safety and cohesiveness, which further supports the change process.

Vulnerability of self

Substance-abusing clients often enter treatment with shattered self-esteem. Defending against this internal vulnerability can become damaging, because clients project their fears onto others. They may try to hide internal vulnerability by appearing hostile and overly self-confident. An atmosphere of safety and empathy enables clients with profound vulnerabilities to enter the process of self-disclosure, through which they become accessible not only to the group but also to themselves. The group facilitator actively encourages such self-disclosure but at the same time emphasizes that individual members need

not disclose any issue they are not yet ready to discuss. Clear boundaries and clear group agreements further support the possibility for self-disclosure.

Regulation of affect

Substance abuse disorders can be perceived as the consequences of trying to control one's emotional life with external substances. This points to a failure of internal regulation that makes the client uncomfortable when feeling emotions that others might consider commonplace. Issues of grief, loss, sadness, and joy can be so affectively charged and linked to the client's past alcohol and drug use that they threaten the client's continued recovery. As mentioned above, the leader's sensitivity to the levels of affective energy in the group is particularly important. Supporting group members to both feel what they are experiencing and at the same time move to a safer and more objective viewpoint regarding those feelings is inherent in MIGP.

Self-care

Substance-abusing clients often present to treatment unaware of internal stresses and pain, having lost sensitivity to physical cues that lead others to the normal self-care functions of daily living. These functions may be as simple as basic hygiene or more complex in terms of boundary setting and relational definitions. Setting boundaries within the group and encouraging heightened sensitivity to self-care are ways in which MIGP addresses this issue. Clients must hear a consistent message that they are worthy of the group's support and, therefore, worthy of their own attention in regard to self-care. All of the above can comfortably be addressed within the context of MIGP, with the leader actively connecting members to members, who support one another on the importance of self-monitoring and care.

Use of Psychodrama Techniques in a Group Setting

Psychodrama has long been effectively used with the substance-abusing client population in a group setting. Wegscheider-Cruse effectively integrated psychodrama as a means to heal family-of-origin issues within the context of addictive behaviors (Wegscheider-Cruse, 1989). The utility of such an intervention seems to be clinically well established. The techniques can help the group move more quickly in terms of self-understanding and relational awareness. The insights gained from the experience of family sculpting (illustrated below) can be worthwhile and potent. However, it is important to stress that psychodrama and other similar expressive therapeutic interventions bring with them a clinical potency that needs to be understood. These interventions can raise anxiety and shame to the point where some clients may be pushed toward relapse or even feel the need to leave treatment to escape the internal conflicts encountered. As with any therapeutic technique, therapists should not utilize such techniques unless they are thoroughly trained and well supervised. Any intervention that has a powerful potential for growth almost always has an equal potential for damage if poorly conducted. Training and appropriate supervision are particularly important with expressive techniques because of their clinical potency.

Psychodrama can be used with different models of group therapy. It offers persons with substance abuse disorders an opportunity to better understand past and present experiences—and how past experiences influence their present lives. This approach encourages clients to relearn forgotten skills,

imaginatively change apparent problems that block progress, rehearse new behaviors, practice empathy, and expand their emotional range by confronting feelings that have never been properly dealt with. As clients act, important concepts become real, internalized, and operational that might otherwise be purely theoretical. Changes experienced through acting become accessible to the psyche as part of the lived history of the individual.

Some therapists use psychodrama to help transform internal dynamics that maintain old patterns relevant to substance abuse. For example, one therapist invites group members to list "rules" in their family of origin. These rules may be related to substance abuse (e.g., "Don't ever say that Mother is drunk. She is taking a nap."). After a client describes a situation in which the rule would be invoked, he assigns family roles to other participants, giving them instructions for how they would behave in this situation. The client is encouraged to break the rule—in the case of the "napping" mother, by insisting on bringing the truth into the open—with the verbal encouragement of all remaining group members who are not playing assigned roles. The client's victory—which can be a transformative, powerful experience—is celebrated as the achievement it is. In this example, the individual experiences himself as a powerful truth-speaker rather than the powerless and voiceless participant he perceived himself to be in the past. This new experience can enhance his sense of self-efficacy and help foster change in his own pattern of substance abuse.

In another example of psychodrama, group participants explore "character defects" such as grandiosity or isolation associated with their pattern of substance abuse. The defects are dramatized, with half the group engaged in the dramatization and half sitting as an audience. For example, persons who experience themselves as isolated sit in the corner or under a table with a "sponsor." The therapist gives them sentences to complete, such as, "I like this corner because…." or "The first time I remember isolating is…." Finally, they are asked to complete the sentence, "I have to get out of this corner because…." The sponsors then gather in a circle and invite the persons they have been supporting to join them, saying, "I want you to join this circle because…." This experience of connection often enhances participants' motivation and ability to change.

A common use of psychodrama in treatment for substance abuse disorders is "sculpting" family members in typical roles and enacting significant situations related to substance abuse patterns. In this process, developed by Papp, family members enact a scene to graphically depict the problem (Papp, 1977, 1983). The physical arrangement of the family members illustrates emotional relationships and conflicts within the family. For example, a family may naturally break up into a triad of the mother, sister, and brother, and a dyad of the father and another sibling. In that case, the therapist might highlight the fact that the mother and father communicate through one of their children and never talk to each other directly.

In yet another form of psychodrama, one person in the group may be asked to give voice to different aspects of her own self that either help maintain dependency or speak for change (sometimes called the "disease" and "recovery" selves). The client might speak from a different chair or position for each of these voices. The intensity of psychodrama often helps compensate for the shorter time span now commonly funded for treatment. Although many participants express concern about acting, the barrier of shyness often drops completely as they enter the process with the assistance of a dynamic and committed facilitator.

Therapeutic Factors

In his classic work, *Theory and Practice of Group Psychotherapy*, Irvin Yalom identified 11 primary "therapeutic factors" in group therapy (Yalom, 1995). Each of these factors has particular importance for clients with substance abuse disorders and can be used to help explain why a group works in a particular way for this client population. These curative factors are present in all group interventions and are listed below.

Instillation of Hope

Many clients come to a treatment setting feeling defeated by life and overwhelmed by their failure to control their use of substances. They feel they have nowhere to go and no possibility for a better outcome in life. When individuals with this life view join a group of people struggling with similar problems, they have the remarkable opportunity of witnessing change in others while at the same time having their own small victories acknowledged and celebrated by group members. Through this process, hope begins to emerge. The energy of hope and the focused attention on this curative factor receive specific attention in the MIGP model.

A variety of exercises can be utilized to further instill hope within substance-abusing clients. Clients can be asked to participate in a visualization exercise where they see themselves in a life without substance use, envisioning particularly how life would be different and better under such circumstances. The group energy fuels this experience and adds the intensity of other clients' support. As with all "guided imagery exercises," the group leader must move with caution. Many substance-abusing clients may not have a picture of life without substances, and consequently such an exercise can be humiliating if not handled sensitively. If the client is unable to visualize, he once again perceives failure. To guard against such potential shaming, the group facilitator can take an active role in the creation of the image, monitoring it for issues of safety with all members of the group as the exercise develops.

Universality

Substance abuse disorders tend to impede relationships and force clients into increased isolation. In a brief group experience, the clients encounter other individuals who have faced similar problems. They become aware that they are not alone in life and can feel tremendous satisfaction in this connection. The sense that their pain is not exclusive or unique and that others with similar problems are willing to support them can be profoundly healing. It helps clients move beyond their isolation, and it gives further energy to hope, which helps to fuel the change process.

Imparting Information

The inevitable exchange of information in a group setting helps members get from one day to the next. Particularly in conjunction with formal psychoeducational groups, MIGP affords group members the opportunity to reflect on what they have learned and at the same time apply that learning within the group setting. The information shared is personal and tends to be experienced as motivational. The client struggling with issues of substance abuse can hear from others how they have dealt with difficult concerns and how they have experienced success. This mutually shared success gives positive energy to the group and encourages change.

Altruism

Fundamental to the human condition is the desire to help others when they are in trouble. Clients struggling with substance abuse disorders tend to be focused on their own difficulties and have a hard time reaching out to help those in need. Group therapy offers the members opportunities to provide assistance

and insight to one another. Particularly within the model of MIGP, the facilitator pays great attention to altruistic moves on the part of members. They are celebrated and acknowledged. As individuals recognize that they have something of value to give their fellow group members, their self-esteem rises as change and self-efficacy are supported.

Corrective Recapitulation of the Primary Family Group

This therapeutic factor pertains to the importance of relationships within the client's family of origin, which invariably finds expression within the group experience. "Recapitulation of the family group" happens when a client—both consciously and unconsciously—relates to another group member as if that person is a member of his family of origin with whom he has struggled in the past. This occurrence is clearly a projection, but it can be identified by the leader, and both group members involved can benefit as they investigate new ways of relating that break the old dysfunctional patterns of the family of origin. In a way, the group begins to serve as a substitute family. The group members are the siblings, and the group facilitator is in a parental role. Even in a time-limited group, issues of transference and countertransference may require attention. However, MIGP tends to dilute the transference by "spreading it throughout the group" rather than concentrating it within the dyadic counseling relationship.

Development of Socializing Techniques

Many substance abusers are "field-sensitive" or "field-dependent" individuals who are keenly conscious of the network of specific relationships as opposed to principles or generalizations that apply regardless of context. Group therapy can take advantage of this trait and use the energy of the relationships to facilitate change. As participants engage in relationships, they learn new social skills that can help them break through their isolation and connect with others in more meaningful ways. They also learn how to disconnect, which is equally important given the anxieties often associated with relational loss and grief. The group facilitator may at times deliberately focus on these social skills through role-playing or modeling exercises within the context of the group itself. The healing takes place as the clients take what they have learned and experienced in group and actively generalize it in their lives outside of the group.

Imitative Behaviors

Imitative behaviors are an important source of learning in group therapy. The process of modeling can be particularly important as clients learn new ways to handle difficult emotions without resorting to violence or drug use. Therapists must be acutely sensitive to the important role they play within this context; clients often look to the therapist to model new behaviors as they encounter new situations within the group context. Group members can also learn by imitating other members who are successfully dealing with difficult relational issues. It is helpful for a new group member to witness an ongoing group where people are confronting their problems appropriately, moving beyond old dysfunctional patterns, and forming new relationships that support change. The group becomes a living demonstration of these new behaviors, which facilitates and supports insight and change.

Interpersonal Learning

Groups provide an opportunity for members to learn about relationships and intimacy. The group itself is a laboratory where group members can, perhaps for the first time, honestly communicate with individuals who

will support them and provide them with respectful feedback. This interpersonal learning is facilitated by the MIGP model, in that special attention is given to relational issues within the context of group.

Group Cohesiveness

Often misunderstood, group cohesion is a sense of belonging that defines the individual not only in relation to herself but also to the group. It is a powerful feeling that one has meaning in relationships and that one is valued. Development of group cohesion is particularly important in the MIGP model, so that group members feel safe enough to take the risks of self-disclosure and change. The experience of belonging is both nurturing and empowering.

Catharsis

Sometimes group participants will gain a sudden insight through interaction with others, which can cause a significant internal shift in the way they respond to life. Such insights may be accompanied by bursts of emotion that release pain or anger associated with old psychological wounds. This process happens more easily in a group where cohesion has been developed and where the therapist can facilitate a safe environment in which emotions can be freely shared. It is important to recognize, however, that although catharsis is a genuine expression, it is not seen as curative in and of itself. High levels of emotional exchange not addressed in the group can become potential relapse triggers, which endanger the success of individual members. The therapist acknowledges the powerful emotions after the member has shared them but asks the group as well as the member to give those emotions meaning and context within the group. Thus, both the experience of the emotion and the understanding of how that emotion either interferes or supports relationships are healing.

Existential Factors

Existential factors of loss and death are often issues of great discomfort in the substance-abusing population. The brevity of a time-limited group experience forces these issues to the surface and allows members to discuss them openly in a safe environment. Time itself represents loss and also serves as a motivator, as the members face the ending of each group session and of the group treatment experience. As they become more aware of the frustrations of reality and the limits they face, clients can receive support from the group in accepting "life on life's terms" instead of their past patterns of escape.

Using Time-Limited Group Therapy

The focus of time-limited therapeutic groups varies a great deal according to the model chosen by the therapist. Yet some generalizations can be made about several dimensions of the manner in which brief group therapy is implemented.

Assessment and Preparation

Client preparation is particularly important in any time-limited group experience. Clients should be thoroughly assessed before their entry into a group for therapy. In terms of exclusionary issues, persons with severe disorders or those who cannot accept support may need to be given more individual time before a group experience. Also, persons with significant deficits in cognition may not benefit as much from a time-limited group.

Group participants should be given a thorough explanation of group expectations. For an MIGP group, for example, they need to understand their responsibility for speaking within the group and that the primary focus of

the group is relationships. A brief explanation of a "here and now" encounter is helpful—the group can become a place where feedback takes place in the "here and now," as members learn how they are affected by the others and how they in turn affect other members. This "here and now" focus brings clients into the present and allows them to deal with real issues within the group that they can then apply in their daily lives. It also distinguishes MIGP from self-help support groups, which traditionally discourage relational "here and now" interactions.

If time permits, it is particularly effective for group members as they are being assessed and prepared for group to either watch or participate in a practice group as a trial experience. A variety of group tapes are available; however, any program can videotape one of its own groups, with appropriate releases for client permission, to use for instructional purposes. This enables new clients to see what will happen in the group session and lowers anxiety. This intentional effort to make the group safe and reduce its inherent anxiety distinguishes MIGP from a more traditionally interactive process group. Introductions to group can also be provided in a psychoeducational format. Clients learn not only what is going to take place in the group but also why and how the group process brings about healing. The importance of relationships and open communications through self-disclosure and support can be explained.

It is important to recognize that although a significant amount of client preparation takes place before the client ever enters a group, client preparation itself is also a process and not an event. Through continual references to the group agreements and group contracts, the therapist continues to prepare clients as they move into the experience.

Initial Session

Opening sessions for group therapy differ according to the type of group, its specific goals, and the personal style of the therapist. In homogeneous, problem-focused groups, for example, less time is needed to define what group members have in common. Opening sessions typically include the following:

- New group members introduce themselves at the opening session, responding to a simple request such as, "Tell us what led you here." Research suggests that if groups do not explicitly address the reason for each member's participation, more members will drop out (Levine, 1967). In the context of substance abuse treatment, the therapist should therefore initially discuss with group members how substance abuse issues will be addressed so as to ensure that focus is maintained.
- The "locus of control" for the group is clarified. Clients explore whether they believe they have the ability to choose effective actions or if they think of themselves as helpless victims of circumstance. For directive groups, in which the therapist exercises greater control, this process will be shorter than for group process groups, in which group members take turns as leaders.
- Goals for the group (and often for individuals) are clarified.
- The therapist seeks to establish a safe, warm, supportive environment. There may be a need to establish rules to increase safety—for example, that members will not engage in physical contact, will not discuss what was said outside the room, and will give feedback to each other in an agreed-upon manner.
- The therapist helps group members establish connections with each other, pointing out common concerns and problems.

Some therapists ask the group to evaluate the opening session. This may be done orally or in writing. The group's success can be measured through the following questions:

- Was substance abuse discussed?
- Did group members listen to each other?
- Did members cooperate and support each other?
- Did they give feedback?

Later Sessions

Often, to enhance continuity, the therapist will begin the next session by recalling the previous one and ensuring that "leftover" items are addressed. The therapist may ask group members how lessons learned in the group have affected their daily lives. Members may have tried to implement suggestions and found they did or did not work, or they may not have tried to do so at all, which is also an important topic of discussion.

On an inpatient unit with clients going through withdrawal or struggling with coexisting psychiatric disorders, instilling hope is particularly important. For the newest clients on the unit, connecting with others who have just been through a similar difficult experience can be inspirational. Such a therapeutic encounter can also reduce issues of shame, as clients connect with others who both share and understand their journey. In addition, the inpatient group can serve as an example of what treatment will be like after discharge and allow the client to "practice" being in a group. Clients can experience the supportive nature of the group, which will reduce their anxiety about future group involvement. Underscoring the impact of brief group interventions, the inpatient process treatment group remains one of the cornerstones of continued change.

Duration of Therapy and Frequency of Sessions

The preferred timeline for time-limited group therapy is not more than two sessions per week (except in the residential settings), with as few as six sessions in all, or as many as 12, depending on the purpose and goals of the group. Sessions are typically 1½ to 2 hours in length. Residential programs usually have more frequent sessions.

Given the dramatically shortened inpatient and residential stays available under managed health care, some have questioned the utility of a process-sensitive treatment group and are focusing on directive educational groups. Even though clients often do not stay more than 3 to 5 days on an inpatient unit, much can be accomplished in this brief timeframe. As mentioned before, directive educational groups are necessary but not always sufficient. Groups with active facilitation, but adhering to process sensitivity, can build cohesion quickly and act as powerful motivators for clients to follow through with the next level of care.

Group process therapy is most effective if participants have had time to find their roles in a group, to "act" these roles, and to learn from them. The group needs time to define its identity, develop cohesion, and become a safe environment in which there is enough trust for participants to reveal themselves. (The exception is an educational group, which relies less on group process factors.) Consequently, prematurely terminated groups relying on group process may be less effective than they could be in promoting long-term change. Furthermore, participants may have to clear their systems of the most serious effects of substances before they can fully participate. Because of such factors, arbitrary time limits for groups, as opposed to timelines set according to the therapeutic goals of the particular group, can be ill advised.

Gender and Cultural Issues Within Groups

Researchers at Cornell University found that social contact with persons who have gone through the same crisis is highly beneficial (Manisses Communications Group, 1997a). Therefore, a common gender, culture and/or

sexual preference will help clients in group therapy share difficulties they may have encountered because of that common background.

Participation in group therapy may be less effective for women than men, perhaps because groups are often dominated by men and reflect their issues and style of interaction (Jarvis, 1992). At this time, however, little research is available on the relative efficacy of women-only rather than mixed-gender groups. Weitz argues that women may have to be empowered in order to remain abstinent (Weitz, 1982). Group cognitive–behavioral therapy has been found to be an effective treatment for women with posttraumatic stress disorder and a substance abuse disorder (Najavits et al., 1996) as well as for women with both a substance abuse disorder and a history of physical or sexual abuse (Manisses Communication Group, 1997).

Covington has written extensively about the importance of women-specific groups, particularly in early recovery. She accurately pointed out that the powerful role definitions within our culture tend to be played out in group and are often oppressive to women (Covington, 1997). In a mixed group, the women quickly become the "emotional containers" for the group and take care of the men. Although such activity is not defined as pathological, it expresses cultural norms wherein women's needs become secondary to those of men, with the women primarily defined as caretakers. They are uncomfortable about bringing up issues of sexuality, particularly sexual abuse, given that men have generally been the abusers (Covington, 1997).

The creation of gender-specific groups, particularly in small agencies or private practice, may pose logistical difficulties. However, there is growing consensus among therapists that, whenever possible, women need to have their own groups, particularly during early recovery (Byington, 1997). This does not suggest that women should be fully segregated from men. Participation in mutually shared psychoeducational experiences and multifamily groups is a therapeutic way of addressing gender issues (Byington, 1997).

Concerns of ethnicity and race should be handled with sensitivity. This is not to suggest that in a time-limited group, the potency of homogeneity is such that each and every ethnic or racial subgroup should be segregated in order to reap the benefits of this intervention. However, cultural issues need to be addressed openly and with sensitivity.

Cost-Effectiveness

The clinical utility of time-limited groups has clearly been demonstrated, but the cost factor is not irrelevant to a consideration of the value of these groups. Although individual work and family work will likely always remain a part of even the briefest time-limited treatment experience, acceptance and use of group interventions are slowly growing. From a cost-management perspective, the benefits are obvious. Not only can the therapist use the power of the group to support change within all group members, but one well-trained group therapist can meet the clinical needs of 8 to 12 clients in roughly the same amount of time as an individual session. When these numbers are enlarged to include more directive approaches such as cognitive–behavioral or psychoeducational groups, the cost–benefit ratio increases.

Appendix A
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Appendix B
Information and Training Resources

General Brief Therapy

American Psychological Association (APA)—Division 29: Psychotherapy

Division of Psychotherapy
P.O. Box 638
Niwot, CO 80544-0638
Phone: (303) 652-9154
Fax: (303) 652-2723
Web site: http://www.cwru.edu/affil/div29/div29.htm
E-mail: lpete@indra.com

APA, headquarted in Washington, DC, is the world's largest association of psychologists. APA's membership includes more than 159,000 researchers, educators, clinicians, consultants, and students. Through its divisions in 50 subfields of psychology and affiliations with 59 State, territorial, and Canadian provincial associations, APA works to advance psychology as a science, as a profession, and as a means of promoting human welfare.

Division 29 promotes education, research, high standards of practice, and the exchange of information among psychologists interested in psychotherapy.

Cognitive–Behavioral Therapy

Aaron T. Beck Institute for Cognitive Studies

Edmund F. O'Reilly, Ph.D.
Founders Hall, Room 319
Assumption College
500 Salisbury Street
P.O. Box 15005
Worcester, MA 01615-0005
Phone: (508) 767-7000, x 7554
Web site: http://www.assumption.edu/
E-mail: eoreill@eve.assumption.edu

The Aaron T. Beck Institute for Cognitive Studies provides information that highlights the contributions of cognitive factors to the resolution of problems in living. The Institute hosts annual speakers and conferences that address research and therapeutic development in cognitive therapy as well as ethical and moral issues. It also sponsors education and training projects in cognitive therapeutic skills to students and to postgraduate professionals.

The Albert Ellis Institute

45 East 65th Street
New York, NY 10021
Phone: (800) 323-4738
Web site: http://www.rebt.org/
E-mail: info@REBT.org

The Albert Ellis Institute, formerly known as the Institute for Rational-Emotive Therapy, is a not-for-profit educational organization founded in 1968. Rational Emotive Behavior Therapy (REBT) is a humanistic, action-oriented approach to emotional growth, first articulated by Dr. Albert Ellis in 1955, which emphasizes individuals' capacity for creating their emotions; the ability to change and overcome the past by focusing on the present; and the power to choose and implement satisfying alternatives to current behavior patterns. An estimated 8,000 mental health professionals participate in Institute training programs and workshops each year.

The Association for Advancement Of Behavior Therapy (AABT)

305 Seventh Avenue - 16th Floor
New York, NY 10001-6008
Phone: (212) 647-1890
Fax: (212) 647-1865
Web site: http://server.psyc.vt.edu/aabt/
E-mail: mebrown@aabt.org

AABT is a not-for-profit membership organization of over 4,500 mental health professionals and students. Founded in 1966, AABT serves as a centralized resource and network for all facets of behavior therapy and cognitive–behavior therapy. It promotes these therapies through its journals, newsletters, annual conventions, Web site, and other educational publications and programs. It also provides opportunities for professional growth and offers information and referral services to the general public, the media, third-party payors, and governmental and nongovernmental agencies.

National Association of Cognitive–Behavioral Therapists (NACBT)

P.O. Box 2195
Weirton, WV 26062
Phone: (800) 853-1135
Fax: (304) 723-3982
Web site: http://www.nacbt.org/
E-mail: nacbt@nacbt.org

NACBT provides information on Rational Emotive Behavior Therapy (Albert Ellis), Rational Behavior Therapy (Maxie Maultsby), Cognitive Therapy (Aaron T. Beck), Rational Living Therapy (Aldo Pucci), and other cognitive–behavioral approaches. NACBT is dedicated to promoting the teaching and practice of cognitive–behavioral therapy and to supporting cognitive–behavioral therapists. NACBT offers cognitive–behavioral workshops, seminars, conferences, and home study certification programs.

Strategic/Interactional Therapies

Brief Family Therapy Center (BFTC)

P. O. Box 13736
Milwaukee, WI 53213-0736
Phone: (414) 302-0650
Fax: (414) 302-0753
Web site: http://www.brief-therapy.org
E-mail: briefftc@aol.com

A not-for-profit research and training center founded in 1978, BFTC has pioneered effective brief therapy methods. The model developed at the center has come to be known as Solution-Focused Brief Therapy. This model has been used successfully for more than a decade in a variety of settings including child protection agencies, community mental health clinics, private practices, sexual abuse programs,

substance abuse treatment, family-based services, and schools.

The Milton H. Erickson Foundation, Inc.

3606 North 24th Street
Phoenix, AZ 85016
Phone: (602) 956-6196
Fax: (602) 956-0519
Web site: http://erickson-foundation.org
E-mail: office@erickson-foundation.org

The Milton H. Erickson Foundation, Inc., is dedicated to promoting and advancing the contributions made to the health sciences by the late Milton H. Erickson, M.D., through training mental health professionals worldwide. More than 60 Milton H. Erickson Institutes and Societies in the United States and abroad have applied to the Foundation for permission to use Dr. Erickson's name in the titles of their organizations. These institutes provide clinical services and professional training in major cities around the world.

Institute for the Study of Therapeutic Change (ISTC)

P.O.B. 578264
Chicago, IL 60657-8264
Phone: (773) 404-5130
Fax: (773) 404-1840
Web site: http://www.talkingcure.com/
E-mail: scottdmiller@talkingcure.com

ISTC is a research, training, and consultation group dedicated to understanding and promoting human change, growth, and potential. ISTC studies how change occurs naturally, spontaneously, and on an everyday basis and then helps people and organizations apply that knowledge in solving problems.

Mental Research Institute

555 Middlefield Road
Palo Alto, CA 94301
Phone: (650) 321-3055
Fax: (650) 321-3785
Web site: http://www.mri.org
E-mail: mri@mri.org

Since 1959, the Mental Research Institute of Palo Alto, California, has been a source of new ideas in the area of interactional/systemic studies, psychotherapy, and family therapy. It offers a variety of workshops and trainings related to brief therapy, narrative therapy, and strategic/interactional therapies.

Humanistic and Existential Therapies

State University of West Georgia

Department of Psychology
1600 Maple Street
Carrollton, GA 30118
Phone: (770) 836-6510
Fax: (770) 836-6717
Web site: http://www.westga.edu/~psydept/index.html
E-mail: meast@westga.edu

The State University of West Georgia Psychology Department is one of the only departments in the country whose theoretical roots are in the humanistic psychology and transpersonal psychology traditions. They offer courses that explore humanistic and transpersonal concerns in psychological theory and therapy.

American Psychological Association (APA)—Division 32: Humanistic Psychology

Will Wadlington, Ph.D.
Center for Counseling & Psychological Services
221 Ritenour
University Park, PA 16802
Phone: (814) 863-0395
Fax: (814) 863-9610
Web site: http://www.apa.org/about/division/div32.html
E-mail: wlw3@psu.edu

Division 32 of the APA (see above), whose foundations include philosophical humanism, existentialism, and phenomenology, seeks to contribute to psychotherapy, education, theory/philosophy, research, organization and management, and social responsibility and change.

Association for Humanistic Psychology (AHP)

45 Franklin Street #315
San Francisco, CA 94102
Phone: (415) 864-8850
Fax: (415) 864-8853
Web site: http://www.ahpweb.org/
E-mail: ahpoffice@aol.com

AHP was formed in 1962 by Abraham Maslow, Carl Rogers, Charlotte Buhler, Rollo May, Virginia Satir, and other founders of the personal growth movement. AHP is a forum for sharing ideas and inspiring community through a full calendar of conferences and events. Members also connect and pursue common interests through self-generated communities and projects called "Energy Centers," which offer personal and professional support and carry out activities and projects on specific issues.

Institute of Transpersonal Psychology (ITP)

744 San Antonio Road
Palo Alto, CA 94303
Phone: (650) 493-4430
Fax: (650) 493-6835
Web site: http://www.itp.edu/
E-mail: itpinfo@itp.edu

ITP is a private, nonsectarian graduate school accredited by the Western Association of Schools and Colleges. For more than 20 years, the Institute has remained at the forefront of psychological research and education, probing the mind–body–spirit connection. The Institute provides dynamic online/distance-learning opportunities using the personal mentor system, as well as an evening master's program for working adults.

Saybrook Graduate School and Research Center

450 Pacific, 3rd Floor
San Francisco, CA 94133-4640
Phone: (800) 825-4480
Fax: (415) 433-9271
Web site: http://www.saybrook.edu
E-mail: saybrook@saybrook.edu.

The Saybrook Graduate School and Research Center provides master's and doctoral programs, research, and communication in humanistic psychology and human science, focused on understanding and enhancing the human experience.

Psychodynamic Therapy

American Psychoanalytic Association (APSA)

309 East 49th Street
New York, NY 10017
Phone: (212) 752-0450
Fax: (212) 593-0571
Web site: http://apsa.org
E-mail: central.office@apsa.org

APSA is a professional organization of psychoanalysts throughout the United States. The association comprises Affiliate Societies and Training Institutes in many cities (listed on their Web site at http://apsa.org/organiz/society.htm) and has about 3,000 individual members. APSA is a Regional Association of the International Psychoanalytical Association.

Alfred Adler Institute of San Francisco

7 Cameo Way
San Francisco, CA 94131
Phone: (415) 282-1661
Web site: http://ourworld.compuserve.com/homepages/hstein/homepage.htm
E-mail: HTStein@worldnet.att.net

The Alfred Adler Institute provides distance training, study-analysis, and case consultation to mental health professionals and students throughout the world via telephone, E-mail, and the Institute's Web site documents. A unique mentor-based service offers self-paced programs through customized training, home study of audio-taped seminars, weekly discussions, and case consultations by telephone.

The C.G. Jung Institutes

The Inter-Regional Society of Jungian Analysts
Wilma H. Spice, Ph.D.
4135 Brownsville Road
Pittsburgh, PA 15227
Phone: (412) 882-7010
Web site: http://www.cgjung.com/irsja.html
E-mail: wspice@ccac.edu

There are a number of independent C.G. Jung Institutes in the United States, all of whom are members of the International Association for Analytical Psychology. In addition to the one listed above, other institutes exist in Washington, D.C., Philadelphia, San Francisco, Los Angeles, Chicago, Dallas, Boston, Santa Fe, New York, Seattle, and Eugene, Oregon. All of these institutes offer training programs, lectures, and workshops. (Contact information for the other Institutes can be found at: http://boulder.earthnet.net/cgjung/)

Family Therapy

American Association for Marriage And Family Therapy (AAMFT)

1133 15th Street, NW, Suite 300
Washington, DC 20005-2710
Phone: (202) 452-0109
Fax: (202) 223-2329
Web site: http://www.aamft.org/
E-mail: Central@aamft.org

AAMFT is the professional association for the field of marriage and family therapy, representing the professional interests of more than 23,000 marriage and family therapists throughout the United States, Canada, and

abroad. The association facilitates research, theory development, and education. AAMFT hosts an annual national training conference each fall as well as a week-long series of continuing education workshops in the summer.

Group Therapy

American Psychological Association (APA)—Division 49: Group Psychology and Group Psychotherapy

Alan M. Orenstein, Ph.D.
9712 DePaul Drive
Bethesda, MD 20817
Phone: (202) 373-7083
Web site: http://www.pitt.edu/~cslewis/GP2/Hello.html
E-mail: alano@erols.com

Division 49 of the APA (see above) provides a forum for psychologists interested in research, teaching, and practice in group psychology and group psychotherapy. Current projects include developing national guidelines for doctoral and postdoctoral training in group psychotherapy.

Association for Specialists in Group Work (ASGW)

Jeremiah Donigian, President
Department of Counselor Education
SUNY College at Brockport
Brockport, NY 14420
Phone: (800) 347-6647
Web site: http://www.colstate.edu/coe/asgw/
E-mail: jdonigia@po.brockport.edu

ASGW was founded to promote quality in group work training, practice, and research, both nationally and internationally. A division of the American Counseling Association (ACA), ASGW numbers among its members more than 5,800 group workers and group work educators. The ASGW Web site provides a resource base for teachers, students, and practitioners of group work and includes both organizational information and professional resources.

Appendix C
Glossary

Attribution(s): An individual's explanation of why an event occurred. Some researchers believe that individuals develop attributional styles (i.e., particular ways of explaining events in their lives that can play a role in the development of emotional problems and dysfunctional behaviors). The basic attributional dimensions are internal/external, stable/unstable, and global/specific. For instance, clinically depressed persons tend to blame themselves for adverse life events (internal), believe that the causes of negative situations will last indefinitely (stable), and overgeneralize the causes of discrete occurrences (global). Healthier individuals, on the other hand, view negative events as due to external forces (fate, luck, environment), as having isolated meaning (limited only to specific events), and as being transient or changeable (lasting only a short time).

Authenticity: In existential therapy, this concept refers to the conscious feelings, perceptions, and thoughts that one expresses and communicates honestly. An individual achieves authenticity through courage and is thus able to define and discover his own meaning.

Classical conditioning: According to this theory, an originally neutral stimulus becomes a conditioned stimulus when paired with an unconditioned stimulus (an event that elicits a response without any prior learning history) or with a conditioned stimulus. This is also referred to as *stimulus substitution*. As applied to substance abuse, repeated pairings between the emotional, environmental, and subjective cues associated with use of substances and the actual physiological effects produced by certain substances lead to the development of a classically conditioned response. Subsequently, when the substance abuser is in the presence of such cues, a classically conditioned withdrawal state or craving is elicited.

Cognitive restructuring: The general term applied to the process of changing the client's thought patterns. Using this process, the therapist identifies distorted "addictive" thoughts in the client and encourages her to search for more rational ways of seeing the same event. The client develops and practices these alternative ways of thinking over the course of cognitive restructuring.

Contact: A term used in Gestalt therapy that refers to meeting oneself and what is other than oneself. Without appropriate contact and contact boundaries, there is no real meeting of the world. Instead, one remains either engulfed by the world or distant from the world and people. The Gestalt therapist tries to help the client make contact with the

present moment rather than seeking detailed intellectual analysis.

Contingency management: A contingency management approach attempts to change those environmental contingencies that may influence substance abuse behavior. The goal is to increase behaviors that are incompatible with use. In particular, contingencies that are found through a functional analysis to prompt as well as reinforce substance use are weakened by associating evidence of substance abuse (e.g., a drug-positive urine screen) with some form of negative consequence or punishment. Contingencies that prompt and reinforce behaviors that are incompatible with substance abuse and that promote abstinence are strengthened by associating them with positive reinforcers.

Core conflictual relationship theme (CCRT): Used in Supportive-Expressive (SE) Therapy, this concept refers to the way in which the client interacts with others and with herself. The CCRT is considered to be the center of a client's problems. It develops from early childhood experiences, but the client is unaware of it and of how it developed. SE therapy posits that the client will have better control over behavior if she knows more about what she is doing on an unconscious level.

Core response from others (RO): A term used in SE therapy to explain one way in which the core conflictual relationship theme is unconsciously developed. The RO represents an individual's predominant expectations or experiences of others' internal and external reactions to himself.

Core response of the self (RS): A term used in SE therapy that helps to develop an individual's core conflictual relationship theme. The RS refers to a more or less coherent combination of somatic experiences, affects, actions, cognitive style, self-esteem, and self-representations.

Counterconditioning: A method that uses classical conditioning principles to make behaviors previously associated with positive outcomes less appealing by more closely associating them with negative consequences. By repeatedly pairing those cues that formerly elicited a particular behavior with negative rather than positive outcomes, the cues lose their ability to elicit the original classically conditioned response; instead, they elicit a negative outcome. This is also called an *aversive* or *counterconditioning* treatment approach.

Countertransference: The phenomenon in which the therapist transfers his emotional needs and feelings onto his client. This can occur to a degree of personal involvement that seriously harms the therapeutic relationship.

Covert sensitization: A technique used in counterconditioning therapy that pairs negative consequences with substance-related cues through visual imagery.

Cue exposure: This principle of classical conditioning holds that if a behavior occurs repeatedly across time but is not reinforced, the strength of both the cue for the behavior and the behavior itself will diminish, and the behavior will eventually vanish. Using cue exposure, a client is presented with physical, environmental, social, or emotional cues associated with past substance abuse (e.g., by accompanying her into an often-frequented bar). The client then is prevented from drinking or taking drugs. This process, over time, leads to decreased reactivity to such cues.

Defense mechanisms: The measures taken by an individual's ego to relieve excessive anxiety. When the environment causes excessive stress, the client's ego will operate

unconsciously to deny, distort, or falsify reality. Defense mechanisms include denial, displacement, grandiosity, introjection, isolation, projection, repression, regression, undoing, and identification with the aggressor.

Deliberate exception: A situation in which a client has intentionally maintained a period of sobriety or reduced use for any reason. For example, a client who did not use substances for a month in order to pass a drug test for a new job has made a deliberate exception to his typical pattern of daily substance use. If he is reminded that he did this in the past, it will demonstrate that he can do so in the future.

Directive approach: This form of group therapy offers structured goals and therapist-directed interventions to enable individuals to change in desired ways. It is a contrast to the process-sensitive approach. The directive approach addresses specific agenda items in a logical order with greater emphasis on content as the primary source of effective change.

Effect expectancies: A set of cognitive expectancies that the client develops concerning anticipated effects on her feelings and behavior as drinking and drug use are reinforced by the positive effects of the substance being taken. These represent the expectation she holds that certain effects will predictably result from drinking or using specific drugs.

Family sculpting: A technique used in family therapy. The therapist "sculpts" family members in typical roles and presents significant situations related to substance abuse patterns. In this process, family members enact a scene to graphically depict the problem. The physical arrangement of the family members can illustrate emotional relationships and conflicts within the family. For example, a family may naturally break up into a triad of the mother, sister, and brother, and a dyad of the father and another sibling. In that case, the therapist might highlight the fact that the mother and father communicate through one of their children and never talk to each other directly.

Functional analysis: A process used in behavioral and cognitive– behavioral therapy that probes the situations surrounding the client's substance abuse. A functional analysis examines the relationships among stimuli that trigger use and the consequences that follow. This can provide important clues regarding the meaning of the substance use behavior to the client, as well as possible motivators and barriers to change. In these forms of therapy, this is a first step in providing the client with tools to manage or avoid situations that trigger substance use. Functional analysis yields a roadmap of a client's interpersonal, intrapersonal, and environmental catalysts and reactions to substance use, thereby identifying likely precursors to substance use.

Insight: A particular kind of self-realization or self-knowledge, usually regarding the connections of experiences and conflicts in the past with present perceptions and behavior, and the recognition of feelings or motivations that have been repressed.

Miracle question: A solution-focused interviewing strategy in which the therapist asks the client the question, "If a miracle happened and your condition were suddenly not a problem for you, how would your life be different?" This forces the client to consider a life without substance use and to imagine himself enjoying that life.

Operant learning: Operant learning refers to the process by which behaviors that are reinforced increase in frequency. Behaviors that result in positive outcomes or that allow the client to avoid negative consequences are likely to increase in frequency. Substance

use in the presence of classically conditioned cues is instrumental in reducing or eliminating the arousal associated with a state of craving, thus serving to reinforce the substance abuse behavior. That is, the behavior serves a basic rewarding function for the individual. For example, an alcohol abuser who drinks to feel more social and less anxious is using substances in an instrumental way. To the extent that she experiences the effects she seeks, the greater the likelihood she will use alcohol under similar circumstances in the future.

Process-sensitive approach: This term consists of two, somewhat different, contrasting types of group psychotherapy. The process-sensitive group approach examines the unconscious processes of the group as a whole, using these energies to help individuals see themselves more clearly and therefore open up the opportunity for change. The first type of process-sensitive approach may be termed the "group-as-a-whole" approach and sees healing as an extension of the individuals within the group as the group comes to terms with a commonly shared anxiety. The second type of process-sensitive approach uses an interactional group process model. By attending to the relationships within the group and helping individuals understand themselves within the relational framework, an interactional group process provides individuals with significant information about how their behavior affects others and how they are in turn affected by other members.

Psychodrama: A method of psychotherapy in which clients act out their personal problems by spontaneously enacting specific roles in dramatic performances performed before fellow clients.

Random exception: An occasion upon which a client reduces substance use or abstains because of circumstances that are apparently beyond his control. The client may say, for example, that he was just "feeling good" and did not feel the urge to use at a particular time but cannot point to any intentional behaviors on his part that enabled him to stay sober. In such instances, the therapist can ask the client to try to predict when such a period of "feeling good" might occur again, which will force him to begin thinking about the behaviors that may have had an effect on creating the random exception.

Selfobject: A term used in self psychology that refers to something or someone else that is experienced and used as if it were part of one's own self. For example, a child is dependent on her parent's love and praise in order to develop a sense of self-worth and self-esteem. In that way, the child internalizes a part of the parent as the selfobject.

Therapeutic alliance: The relationship between the therapist and client. In all psychodynamic therapies, the first goal is to establish a "therapeutic alliance" between therapist and client, because this association functions as the vehicle through which change occurs. A therapeutic alliance requires intimate self-disclosure on the part of the client and an empathic and appropriate response on the part of the therapist. In brief psychodynamic therapy, this alliance must be established as soon as possible, and the therapist must be able to establish a trusting relationship with his client in a short time.

Transference: The process, basic to all psychodynamic therapies, of the client's transference of salient characteristics of unresolved conflicted relationships with significant others onto the therapist. For example, a client whose relationship with her father is deeply conflicted may find herself reacting to the therapist as if he were her

father. An initial goal of brief psychodynamic therapy is to foster transference by building the therapeutic relationship. Only then can the therapist help the client begin to understand her reasons for using substances and to consider alternative, more positive behavior.

Transpersonal awakening: The process of awakening from a lesser to a greater identity in transpersonal psychotherapy. This form of therapy uses the healing nature of subjective awareness and intuition in the process of awakening and employs the therapeutic relationship as a vehicle for this awakening in both client and therapist.

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Appendix D
Health Promotion Workbook

Reprinted with permission from Barry, K.L., and Blow, F.C., 1998.

Part 1: Summary of Health Habits

Let's review some of the information about your health, behavior, and health habits that we discussed in the clinic.

Exercise

Days per week you participated in vigorous activity

- ❑ none
- ❑ seldom
- ❑ 1–2 days per week
- ❑ 3–5 days per week
- ❑ 6–7 days per week

Minutes of exercise per day

- ❑ not applicable
- ❑ fewer than 15 minutes
- ❑ 15–30 minutes
- ❑ more than 30 minutes

Nutrition

Weight change in last 6 months

- ❑ no change in weight
- ❑ gained more than 10 pounds
- ❑ lost more than 10 pounds
- ❑ don't know

Tobacco Use

Tobacco used in last 6 months

- ❑ no
- ❑ yes

If yes, which ones?

- ❑ cigarettes
- ❑ chewing tobacco
- ❑ pipe

Average cigarettes smoked per day in last 6 months

- ❑ not applicable
- ❑ 1–9
- ❑ 10–19
- ❑ 20–29
- ❑ 30+

Alcohol Use

Drinking days per week

- ❑ 1–2 days per week
- ❑ 3–4 days per week
- ❑ 5–6 days per week
- ❑ 7 days per week

Drinks per day

- ❑ 1–2 drinks
- ❑ 3–4 drinks
- ❑ 5–6 drinks
- ❑ 7 or more

Binge drinking within last month (5 or more drinks per occasion for women; 6 or more drinks per occasion for men)

- ❑ none
- ❑ 1–2 binges
- ❑ 3–5 binges
- ❑ 6–7 binges
- ❑ 8 or more

Are there any of these health behaviors (exercise, nutrition, tobacco use, alcohol use) with which you would like some help?

- ❑ no
- ❑ yes

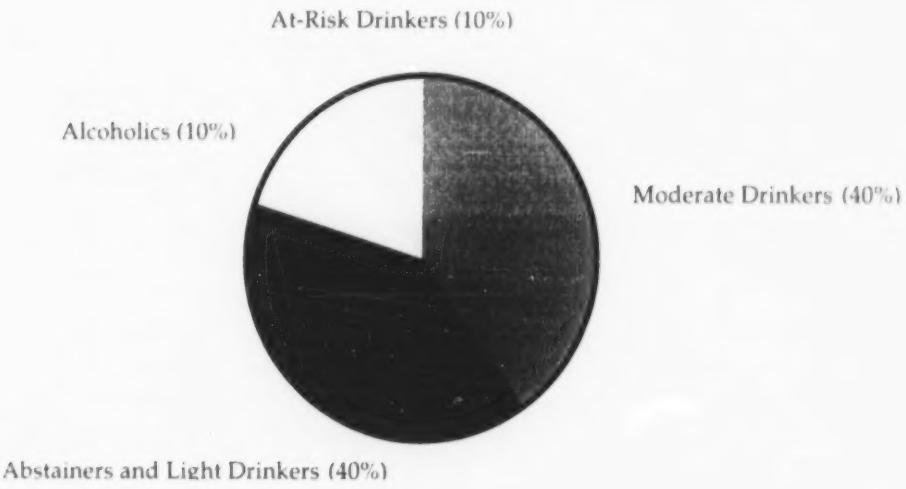
If yes, which ones?

- ❑ exercise
- ❑ nutrition
- ❑ tobacco use
- ❑ alcohol use

Part 2: Types of Drinkers in the U.S. Population

It is helpful to think about the amount of alcohol consumed by adults in the United States and by you. There are different types of drinkers among the adult population, and these types can be explained by different patterns of alcohol consumption. These include:

Types	Patterns of Alcohol Consumption
Abstainers and light drinkers	■ Drink no alcohol or fewer than 3 drinks per month ■ Alcohol use does not affect health or result in negative consequences ■ Pregnant and breastfeeding women are advised to drink **NO** alcohol
Moderate drinkers	■ Drink 3 or fewer times per week ■ Drink 1–3 standard drinks per occasion ■ Alcohol use does not affect health or result in negative consequences ■ At times moderate drinkers consume **NO** alcohol, such as before driving, while operating machinery, while pregnant, etc.
At-risk drinkers	■ Drink over 12 (women) and 15 (men) standard drinks per week ■ At risk for negative health and social consequences
Alcoholics	■ Heavy drinking has led to physical need for alcohol and to other problems



Part 3: Consequences of Heavy Drinking

Drinking alcohol can affect your **physical health, emotional and social well-being**, and **your relationships with others**. The following are some of the positive effects that people sometimes describe as a result of drinking alcohol.

- Temporary high
- Forget one's problems
- Enjoy the taste
- Social ease
- Relaxation
- Sense of confidence and daring
- Temporarily reduced stress levels
- Avoid uncomfortable feelings
- Ease in speaking one's mind

The following are some of the **negative consequences** that may result from drinking.

- Difficulty coping with stressful situations
- Depression
- Blackouts
- Problems at work or school
- Liver problems
- Sexual performance problems
- Sleep problems
- Arrests for driving under the influence of alcohol
- Sexually transmitted diseases
- Car crashes
- High blood pressure
- Accidents/injuries
- Relationship problems
- Increased risk of sexual assault
- Financial problems
- Stomach pain

Part 4: Reasons To Quit or Cut Down on Your Drinking

The purpose of this step is to think about the best reason for you to quit or cut down on your drinking. The reasons will be different for different people.

The following list identifies some of the reasons why people decide to cut down or quit drinking. Check each box by the three most important reasons why YOU want to quit or cut down on your drinking. Perhaps you can think of other reasons that are not on this list.

- ❑ To consume fewer empty calories (alcoholic drinks contain many calories)
- ❑ To sleep better
- ❑ To live longer—probably between 5 and 10 years longer
- ❑ To look younger
- ❑ To be less likely to die of heart disease or cancer
- ❑ To save lots of money
- ❑ To be happier
- ❑ To reduce the possibility that I will die of liver disease
- ❑ To reduce the possibility that I will die in a car crash
- ❑ To achieve more in my life
- ❑ To do better at my job
- ❑ To be a better father/mother to my children
- ❑ Other: _____

Write down the three most important reasons you chose to cut down or quit drinking.

1. _____

2. _____

3. _____

Think about the consequences of continuing to drink heavily. Now think about how your life might improve if you change your drinking habits by cutting down or quitting. What improvements do you anticipate?

Physical health:

Mental health:

Family:

Other relationships:

Work/school:

Financial:

Legal:

Part 5: Drinking Agreement

The purpose of this step is to decide on a drinking limit for yourself for a particular period of time. Negotiate with your health care provider so you can both agree on a reasonable goal. A reasonable goal for some people is abstinence--not drinking any alcohol.

As you develop this agreement, answer the following questions:

- How many standard drinks (see below)?
- How frequently?
- For what period of time?

DRINKING AGREEMENT

Date: _____

_____

_____

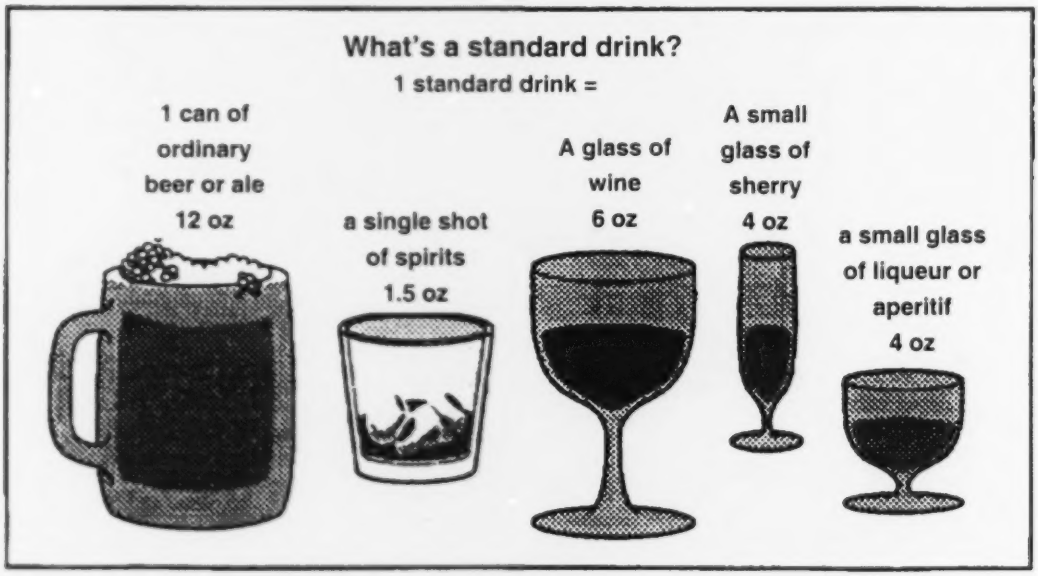
_____

_____

Patient signature: _____

Physician signature: _____

The drinks shown below in normal measure contain roughly the same amount of pure alcohol. You can think of each one as a **standard drink**.


What's a standard drink?
1 standard drink =
1 can of ordinary beer or ale 12 oz
a single shot of spirits 1.5 oz
A glass of wine 6 oz
A small glass of sherry 4 oz
a small glass of liqueur or aperitif 4 oz

Drinking Diary Card

One way to keep track of how much you drink is the use of drinking diary cards. One card is used for each week. Every day record the number of drinks you have. At the end of the week add up the total number of drinks you had during the week.

Diary Card

KEEP TRACK OF WHAT YOU DRINK OVER THE NEXT 7 DAYS

STARTING DATE _____

Day	Beer	Wine	Liquor	Number
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
			WEEK'S TOTAL:	

Part 6: Handling Risky Situations

Your desire to drink may change according to your mood, the people you are with, and the availability of alcohol. Think about your last periods of drinking.

Here are examples of risky situations. The following list may help you remember situations that can result in at-risk drinking.

- Parties
- Boredom
- Tension
- Feeling lonely
- Feelings of failure
- Frustration
- Use of tobacco
- Sleeplessness
- Family
- Friends
- Criticism
- Dinner parties
- Children
- TV or magazine Ads
- Anger
- Watching television
- Other people drinking
- Certain places
- After work
- Weekends
- Arguments

What are some situations that make you want to drink at a risky level? Please write them down.

1. _____

2. _____

Ways To Cope With Risky Situations

It is important to figure out how you can make sure you will not go over drinking limits when you are tempted. Here are examples:

- Telephone a friend
- Call on a neighbor
- Read a book
- Go for a walk
- Watch a movie
- Participate in a sport

Some of these ideas may not work for you, but other methods of dealing with risky situations may work. Identify ways in which you could cope with the specific risky situations you listed above.

1. For the first risky situation or feeling, write down different ways of coping.

_____

_____

2. For the second risky situation or feeling, write down different ways of coping.

_____

_____

Think about other situations and ways in which you could cope without using alcohol.

Visit Summary

We have covered a great deal of information today. Changing one's behavior, especially drinking patterns, can be a difficult challenge. The following pointers may help you stick with your new behavior and maintain the drinking limit agreement, especially during the first few weeks when it is most difficult.

- Remember that you are changing a habit and that it can be hard work. It becomes easier with time.
- Remember your drinking limit goal: _____
- Read this workbook frequently.
- Every time you are tempted to drink above limits and are able to resist, congratulate yourself because you are breaking an old habit.
- Whenever you feel very uncomfortable, tell yourself that the feeling will pass.
- At the end of each week, think about how many days you have been abstinent (have consumed no alcohol) or have been a light or moderate drinker.
- Some people have days during which they drink too much. If that happens to you, DON'T GIVE UP. Just start again the next day.

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